Jan. 27. 2011 8-544M

Shring Mill Health Campus

No. 7113

O u ii	. 27. 2011 0.31	was obiting mitit nearth	ounipu.	_	~(<i>l</i>)		
		I AND HUMAN SERVICES				PRINTED: FORM OMB NO.	APPROVE E
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTI	PLE CONSTRUCTION	(X3) DATE SL	RVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DIN	G	COMPLE	TED
	<i>,</i> .••	4,5,5,5,4	B. WIN	G			
		155764				01/14	W2011
NAME OF F	ROVIDER OR SUPPLIER	•			REET ADDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAMP	US		-	01 W 87TH AVE FERRILLVILLE, IN 48410	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	TS .	F 0	00	Survey Event ID: 8SXV11		
		·			The submission of this P	lan of	
		Recertification and State			Correction does not indi	cate an	
	Licensure Survey.				admission by Spring Mill	Health	
	Survey dates: Janu	uary 10, 11, 12, and 14, 2011			Campus that the findings	and	
	-				allegations contained he	rein are	
	Facility Number.				accurate and true		
	Provider Number: Aim Number: N/A				representations of the q	uality	
	THE PROPERTY OF				of care and services pro	vided to	
al	Survey Team:				the residents of Spring	Mill	
/A	Sheila Sizemore, R	N, TC		ļ	Health Campus. This fac	ility	
111	Marcia Mital, RN Kelly Sizemore, RN			ı	recognized it's obligati	on to	
I DE WIE	Regina Sanders, R				provide legally and medi	cally	
$\mathcal{N}(\mathcal{N})$	(January 11, 12, an	d 14, 2011)			necessary care and servi	ces to	
N/2	Census bed type:	TO BY ANY 12 YEAR			its residents in an econ	omic and	
J	SNF: 37	RECEIVED			efficient manner. The f	acility	
	Residential: 57				hereby maintains it is i	n	
	Total: 94	FED 4 2011			substantial compliance w	ith the	
	Census Payor Type	FEB - 4 2011			requirements of particip	ation	
	Medicare: 30				for comprehensive health	care	
ļ	Other: 64	LONG TERM CARE DIVISION	rti		facilities (for Title 18	/19	
	Total: 94	IDIANA STATE DEPARTMENT OF HEALT	11		programs).	ŀ	
	Sample:	10			To this end, this plan o	£	
	Supplemental samp	ole: 5			correction shall serve a	s the	
	Residential Sample				credible allegation of		-
	Supplemental Resid	dentiai Sample: 1			compliance with all state	e and	
l	These deficiencies	also reflect state findings in			federal requirements gove	erning	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

accordance with 410 IAC 16.2.

F 157 483,10(b)(11) NOTIFY OF CHANGES

SS=D (INJURY/DECLINE/ROOM, ETC)

Cathy Emswiller RN

Quality review completed 1-19-11

F 157

of statue only.

TITLE

the management of this facility.

It is thus submitted as a matter

(XB) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is regulate to continued program participation.

ORIGINAL

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No. 7113 P. 5

AH "A" FORM

	Die Michiga and William Charles Carl			A POR						
	OF ISOLATED DEFICIENCIES WHICH CAUSE ITH ONLY A POTENTIAL FOR MINIMAL HARM	PROVIDER#	MULTIPLE CONSTRUCTION A BUILDING	DATE SURVEY COMPLETE:						
OR SNFs AN	D NFs	155764	B. WING	1/14/2011						
	OVIDER OR SUPPLIER HLL HEALTH CAMPUS	STREET ADDRESS, CITY, STAT 101 W 87TH AVE MERRILLVILLE, IN	TE, ZIP CODE							
d Refox										
AG	SUMMARY STATEMENT OF DEFICIEN	ICTES .								
F 441	483.65 INFECTION CONTROL, PREV	VENT SPREAD, LINENS								
	The facility must establish and maintain and comfortable environment and to hel									
	 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. 									
,	 (b) Preventing Spread of Infection (1) When the Infection Control Program infection, the facility must isolate the resident of the facility must prohibit employees contact with residents or their food, if display the facility must require staff to was washing is indicated by accepted profess. 	sident. s with a communicable disea irect contact will transmit th sh their hands after each dire	se or infected skin lesions from e disease.	ı direct						
	(c) Linens Personnel must handle, store, process ar	nd transport linens so as to p	revent the spread of infection.							
	This REQUIREMENT is not met as ever Based on observation and interview, the related to 2 of 2 linen cart covers which potential to affect 23 residents who residents	facility failed to transport li were cracked and torn on I								
	Findings include:	Findings include:								
		During the environmental tour with the Maintenance Director on 01/12/11 at 3 p.m. through 3:30 p.m., there were two linen carts stored in the, "Spa Room". The covers of both carts were cracked and had small tears.								
	During an interview at the time of the ob- covers were cracked.	servation, the Maintenance	Director acknowledged the line	en cart						
	3.1-19(g)									
	1			•						

Any deficiency statement ending with an extensisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other enfoguards provide sufficient protection to fite particula. (See instructions.) Except for nursing homes, the findings sated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.

For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

F-441 Infection Control

- 1. Facility infection control manual reviewed and no negative outcomes were noted.
- 2. All residents had potential to be affected. Reviewed facility infection control manual and no negative outcomes were noted.
- 3. Linen carts and covers were replaced.
- 4. The Director of Plant Operations or designee will audit the linen carts and covers as part of the preventative maintenance program. QA Committee will review trends monthly.
- 5. February 13, 2011

PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SI COMPLE	
		155764	B. WING _		01/1	4/2011
	ROVIDER OR SUPPLIER	us	1	REET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410	<u></u>	72911
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPREDEDICIENCY)	JID BE	(X5) COMPLETION DATE
F 157	consult with the resknown, notify the resknown, notify the reor an interested fam accident involving the injury and has the printervention; a significant in hear status in either life to clinical complication significantly (i.e., a rexisting form of treatment); or a decitive the resident from the §483.12(a). The facility must also and, if known, the reor interested family change in room or respecified in §483.12 resident rights under regulations as specified in specif	ediately inform the resident; ident's physician; and if sident's legal representative nily member when there is an the resident which results in otential for requiring physician ficant change in the resident's psychosocial status (i.e., a lith, mental, or psychosocial hreatening conditions or as); a need to alter treatment need to discontinue an atment due to adverse or commence a new form of sision to transfer or discharge to facility as specified in the promotive of the resident's legal representative member when there is a commate assignment as 5(e)(2); or a change in a rederal or State law or ified in paragraph (b)(1) of the cord and periodically update one number of the resident's or interested family member.		F-157 Physician Notificate 1. Resident #22 and #8 their physicians notified time of survey. They have evaluated by their physicians note 2. Current residents Mill be reviewed for the days. The facility guidel will be followed for any requiring notification. 3. The licensed staff in serviced on the facility guidelines of physician notification. The diabeticand the MAR's will be rev the Unit Manager at least a week for any findings r hotification. 4. The DHS or designee review the Medication Administration Record (MAR) diabetic records, and the report at least 5 days per until 100% compliance is for 3 weeks, then at least per week as part of the or DA process. Results will be reviewed by the facility (reviewed by the facility)	at the re been rians and rians are r	
	failed to ensure residuation	view and interview, the facility dents' physician's were on refusal and an elevated 10 residents reviewed for		Committee.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 85XV11

Facility ID: 010739

If continuation sheet Page 2 of 44



Jan. 27. 2011 8:55AM Spring Mill Health Campus

Mill Health Campus No. 7113

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILL	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155764	B, WING		- 01/1	4/2011
-	ROVIDER OR SUPPLIER MILL HEALTH CAMP	US	5	STREET ADDRESS, CITY, STATE, ZIF 101 W 87TH AVE MERRILLVILLE, IN 46410		7241
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 157		cians in a sample of 10.	F 18	57		
:	1/12/11 at 9:55 a.m	record was reviewed on Resident #22's diagnoses not limited to diabetes mellitus, d dementia.		•		
	indicated to check to twice a day and to o	er recapitulation, dated 1/11, the resident's blood sugars call the physician if the gar was greater than 400.				
	indicated the reside 4:00 p.m., was 429.	etic monitoring flow record, ent's blood sugar on 1/3/11 at . The form indicated the notified of the blood sugar.				
	documentation to in	or the above date, lacked adicate the physician had been ent's 429 blood sugar.				
	LPN #1 indicated the notified of the reside 2. Resident #87's c 1/12/11 at 12:10 p.r included, but were resident #87's concluded.	on 1/12/11 at 10:45 a.m., see physician should have been ent's blood sugar over 400, closed record was reviewed on m. Resident #87's diagnoses not limited to, stage 4 renal fa, and cerebral vascular oke).				
	Heparin (blood thin	dated 10/05/10, indicated ner) 5,000 units twice a day.		·	·	
	Record, indicated R	Medication Administration esident #87 had refused the the Heparin medication on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PRÖVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			1	,	, -	
		155764	B. WING		01/14/2011	
	PROVIDER OR SUPPLIER	us	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 157	resident's record of the resident's refusithe Heparin medical During an interview DoN indicated Resibeen notified of the Heparin medication A facility policy, date Notification Guideling resident's physician testing results or channer to evaluate provision of appropriate the resident's physician testing results or channer to evaluate provision of appropriate the resident's resident's physician testing results or channer to evaluate provision of appropriate the resident's resident's resident's resident's resident's resident's resident's resident's refusion and resident's refusion refusion resident's refusion resident's refusion resident's refusion refusion resident's refusion resident's refusion ref	7, 8, and 9, 2010. If documentation in the the physician being notified of all of the dinner time dose of ation. on 1/12/11 at 5:20 p.m., the dent #87's physician had not resident's refusal of the	F 157	F-176 SELF Administratio	n of	
	DRUGS IF DEEME An individual reside the interdisciplinary §483.20(d)(2)(ii), ha practice is safe. This REQUIREMEN by: Based on observation interview, the facility had been assessed administer her own resident administeric (breathing treatment)	nt may self-administer drugs if team, as defined by as determined that this as determined that this are less to medication related to, a ng a nebulizer treatment to independently for 1 resident ewed for medications in a	F 176	Drugs 1. The assessment was completed on resident # time of survey. The resi evaluated and no negative ffects were noted. 2. Current residents utilizing hand held nebu have been evaluated regatheir ability to administ their own drugs via this of delivery. Family and physicians will be notifiany results indicating the unable to utilize the hand nebulizer.	dent was e lizers rding ter method ied of ney are	

No. 7113 P. 10 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI COMPLET (X4) DENTIFICATION NUMBER: A BUILDING					
		155764	B. WING		01/1	4/2011
	PROVIDER OR SUPPLIER	us		REET ADDRESS, CITY, STATE, ZIP 101 W 87TH AVE MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
F 176	Continued From pa	ge 4	F 170	F-176 Continued		
	wheelchair on 1/11. Resident #3 was of nebulizer machine: her mouth and beg. There were no staff time in the resident. Resident #3's record 12:00 p.m. Reside were not limited to, congenital mitral insidementia, and eder "Albuterol (a medical resident and eder "Albuterol").	d was reviewed on 1/10/11 at nt #3's diagnoses included, but congestive heart failure, sufficiency, pleural effusion, ma. dated 12/04/10, indicated ation to improve breathing) nt) every 8 hours for sob		3. Licensed staff serviced on the criprocess of self admassessments with handlizers. 4. The DHS or dereview all new administration orders for administration nebulizer treatment held nebulizer as prongoing QA process.	iteria and the ministration and held esignee will its and/or netration of the part of the	e
	medication assessment administer medication assessment. A quarterly MDS (Massessment, dated #3's cognitive (menimpaired. During an interview hallway with LPN #3 did not have a self assessment. LPN amedication for the basessment.	self administration of nent or a physician's order to lications.				

Jan. 27. 2011 8:55AM Spring Mill Health Campus

No. 7113

3 P. 11 PRINTED: 01/21/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:	A. BUILDING		G	COMPLETED		
		155764	Ð. WIN	G_		01/14/2011		
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	บร	STREET ADDRESS, CITY, STATE, ZIP GO 101 W 87TH AVE MERRILLVILLE, IN 48410					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(XS) COMPLETION DATE	
F 176	Continued From pa	ge 5	F 1	76				
	Nurse Consultant in self administration of	on 1/11/11 at 9:11 a.m., the odicated the resident needed a of medication assessment, ant indicated LPN #2 had on in the cup.			·	.		
	a.m., still continuing	served on 1/11/11 at 9:14 her breathing treatment in ere no staff present in the						
	Healthcare Unit Ma	on 1/11/11 at 10:35 a.m., the nager indicated she had just ministration of medication sident #3.	,					
	"Residents who des medications are per interdisciplinary teal	of Medications" indicated sire to self-administer mitted to do so if the facility's m has determined that the afe for the resident and other						
F 272 SS=E	3.1-11(a) 483.20, 483.20(b) C ASSESSMENTS	OMPREHENSIVE	F 2	72	F-272 Comprehensive Asse	ssments		
	a comprehensive, a	nduct initially and periodically courate, standardized ment of each resident's			assessments on residents 27, and 29 cannot be cor- since they are in the pa- residents were evaluated	rected st. The		
	specified by the Sta include at least the t	sident's needs, using the RAI te. The assessment must			negative outcome noted. The time of survey.	I	·	

STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE S COMPLE	
		155764	B. Wil	1G		01/1	4/2011
SPRING	PROVIDER OR SUPPLIER MILL HEALTH CAMP		_	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 272	Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-b Physical functioning Continence; Disease diagnosis a Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments: Discharge potential Documentation of s the additional assessment Documentation of p This REQUIREMEN by: Based on record revialed to ensure assessment Documentation of p This REQUIREMEN by: Based on record revialed to ensure assessment (Residents #3, #5, # Findings include: 1. Resident #18's re 1/11/11 at 9:30 a.m. included, but were in shoulder, dementia,	patterns; eing; g and structural problems; and health conditions; al status; and procedures; ummary information regarding sment performed through the nt protocols; and articipation in assessment. IT is not met as evidenced view and interview, the facility essments were complete and skin conditions, vital signs, are Area Assessment), for 5 ewed for complete and nts in a sample of 10. 18, 27, and #29) ecord was reviewed on Resident #18's diagnoses not limited to, fractured right and depression.	F		F-272 Continued 2. All residents have potential to be effected alleged deficient practi relating to the daily sk assessments. The MDS coordinators will review last 90 days of MDS's wifor appropriate summary to the assessment. 3. The licensed staff in-serviced on the appropriate of the daily nursing assessment. The coordinators have been in serviced on the CAA proced. The DHS or designed review the daily skilled charting for completeness particular the safety, slyvital signs at least 5 cm week. CAA's will be review when completed until 100% compliance is achieved for weeks, then at twice week 6 months. Thereafter, it part of the ongoing QA monitoring process quarter.	by the ce illed the the CAA's related will be priate skilled MDS neess. He will sin cin, and days a lewed style for will be	
	resident#18'S adm	ission MDS (minimum data					

Jan. 27. 2011 8:55AM Spring Mill Health Campus

DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 7113 P. 13 PRÍNTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		155764	B. WIN	IG_		01/1/	4/2011
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	บร		1	REET ADDRESS, CITY, STATE, ZIP CODE 01 W 87TH AVE MERRILLVILLE, IN 46410		12011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD B≝	(X5) COMPLETION DATE
F 272	date of 12/1/10, ind Assessment Summ drug use. The CAA attached summary" There was a lack of for psychotropic drub. During an interview MDS coordinator #' been a completed of drug use for the research of the was a session of 12/6/2 indicated the following 12/8/10 the pressure thickness loss with muscle. Slough or some parts of the was 12/15/10 the pressure 12/15/10 the pressure 12/15/10 the pressure 12/15/10 at 10:15 and 12/15/10 at 10:30 a.m., 12/25/10:30 a.m., 12/25/10:30 a.m., 12/25/10	ith an assessment reference icated the Care Area hary triggered for psychotropic a Summary indicated to "see for psychotropic drug use. If documentation of a summary it is use. on 1/11/11 at 11:10 a.m., I indicated there should have CAA summary for psychotropic ident. ecord was reviewed on m. Resident #29's diagnoses not limited to, dementia, hypertension. seessment form, indicated the rected deep tissue injury upon 10 on her right heel. The forming: e ulcer was a stage IV (full exposed bone, tendon or eschar may be present on	F2	272			
	acting parker to the th	no doddinented, 12/23/10 At					,

Jan. 27. 2011 8:56AM Spring Mill Health Campus

No. 7113 P. 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155764	B. WIN				
NAME OF P	ROVIDER OR SUPPLIER	100/04		CTDE	EET ADDRESS, CITY, STATE, ZIP CODE		4/2011
	MILL HEALTH CAMP	us		10	1 W 87TH AVE ERRILLVILLE, IN 46410	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUSY BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Continued From pa 8 a.m., 12/30/10 at 12:15 p.m. all indica impairment. During an interview LPN unit manager i were not correct be impairment. 3. Resident #3's read at 12:00 p.m. Resident were not limited congenital mitral insidementia, and eder A Skilled Nursing A Collection form, dat the sections were lead to the commentation of the A Skilled Nursing A Collection form, dat documentation of the A Skilled Nursing A Collection form, dat documentation of the A Skilled Nursing A Collection form, dat documentation of the A Skilled Nursing A Collection form, dat documentation of the A Skilled Nursing A Collection form, dat documentation of the A Skilled Nursing A Collection form, dat documentation of the A Skilled Nursing A Collection form, dat documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form, data documentation of the A Skilled Nursing A Collection form form form form form form form form	ige 8 12:30 p.m., and 1/2/11 at ated the resident had no skin on 1/10/11 at 1:30 p.m., the indicated the assessments scause the resident had skin cord was reviewed on 1/10/11 dent #3's diagnoses included, I to, congestive heart failure, sufficiency, pleural effusion, ma. ssessment and Data ted 12/16/10, indicated all of		272			
	Collection form, dat documentation of the A Skilled Nursing A Collection form, dat	ed 12/30/10, lacked ne type of pulse and the site. ssessment and Data					
	GOGUNENIARON ON U	ie type or pulae and the alte.					

Jan. 27. 2011 8:56AM Spring Mill Health Campus

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 7113 P. 15 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155764	B. WIN	IG		01/1	1 /2011
	ROVIDER OR SUPPLIER	us		10	EET ADDRESS, CITY, STATE, ZIP CODE 11 W 87TH AVE ERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 272	During an interview Nurse Consultant in pertinent to the assout. 4. Resident #5's reat 10:05 a.m. Residual were not limited difficulty in walking, Skilled Nursing Assforms, dated Decerand January 1, 2, a documentation of thad in place. During an interview Healthcare Unit Maassessment should 5. Resident #27's r 1/11/11 at 10:37 a.t included, but were reallure, hypertension hypertrophy (enlarg original admission of A Pressure/Stasis// Assessment, dated resident had a presswas present on admission Assilled Nursing Assilled Nursi	on 1/10/11 at 12:44 p.m., the edicated "the vitals are essment and should be filled at cord was reviewed on 1/11/11 dent #5's diagnoses included, it to, Alzheimer's Disease, and osteoporosis. Sessment and Data Collection mber 26, 27, 29, 30, 31, 2010 and 4, 2011, lacked he type of alarm the resident for an 1/11/11 at 10:45 a.m., the mager indicated the laccord was reviewed on m. Resident #27's diagnoses not limited to, congestive heart in, and benign prostatic red prostate). Resident #27's date was 10/19/10. Arterial/Diabetic Ulcer 10/20/10, indicated the sure area on the meatus and mission. Sessment and Data Collection resident did not have any skin following dates:	Fí	272			
				- 1			

Jan. 27. 2011 8:56AM Spring Mill Health Campus

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 7113 P. 16
PRINTED: 01/21/2011
FORM APPROVED
OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULYI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING _			
·		155764	D. WING_		01/1	4/2011
	ROVIDER OR SUPPLIER MILL HEALTH CAMF	PUS	1	REET ADDRESS, CITY, STATE, ZIP CODE 01 W 87TH AVE MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 272	Continued From pa	age 10	F 272			
	During an interview	with LPN #1, on 1/12/11 at licated the skin assessments				
	3.1-31(a) 483.20(g) - (j) ASS ACCURACY/COOI	ESSMENT RDINATION/CERTIFIED	F 278	1. The MDS's on resid	lents #	
	The assessment massident's status.	nust accurately reflect the		3,8,18, and 22 were corr the time of the survey. 2. The MDS's of the co		
	A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.		residents will be review accuracy and appropriate corrections made as indi	1		
3			3. The MDS coordinate been in-serviced on MDS	rs have	 	
		o completes a portion of the sign and certify the accuracy of assessment.		accuracy. 4. The DHS or designe review MDS's upon comple accuracy until 95% accur	tion for	
	willfully and knowin false statement in a subject to a civil mo \$1,000 for each asswillfully and knowin to certify a material resident assessme	d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each		achieved for 3 months. M will be reviewed by the office support team at 1 quarterly for accuracy a of the ongoing QA proces	DS's home east s part	2/13/11
		ent does not constitute a statement.				
	This REQUIREMENT by:	NT is not met as evidenced				

Jan. 27. 2011 8:56AM . Spring Mill Health Campus

No. 7113 P._ 17

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		155764	B. WING	- Co Lab L	01/1	4/2011	
	SPRING MILL HEALTH CAMPUS			ET ADDRESS, CITY, STATE, ZIP I W 87TH AVE ERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X6) COMPLETION DATE	
F 278	Based on record re failed to ensure MD Assessments were to missed diagnose influenza vaccine for	view and interview, the facility (S) (Minimum Data Set) completed accurately, related is, a pressure ulcer, and an or 4 of 10 residents reviewed S's in a sample of 10.	F 278			·	
	at 12:05 p.m. Resid but were not limited hypertension, anxie	,	i				
	diagnoses of depres A Quarterly MDS As	ssessment, dated 12/24/10, on for the diagnoses,			·		
į	1/11/11 at 10:10 a.r	with MDS Coordinator #2, on n, she indicated anxiety and nave been checked on the					
	at 12 p.m. Residen were not limited to,	cord was reviewed on 1/10/11 t #3's diagnoses included, but congestive heart failure, sufficiency, edema, pleural ntia.					
		oitulation Order, dated 1/1/11 licated a diagnosis of					
		sessment, dated 1/4/11, on for the diagnosis of					

No. 7113 P. 18 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLÍA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		1557 64	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	100104	ISTR	EET ADDRESS, CITY, STATE, ZIP C		4/2011
SPRING	MILL HEALTH CAMP	ບຣ	10	01 W 87TH AVE IERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X6) COMPLETION DATE
F 278	dementia. During an interview 1/11/11 at 9:37 a.m should have been of 3. Resident #18's r 1/11/11 at 9:30 a.m included, but were a shoulder, dementia Resident #18's adm set) assessment, with date of 12/1/10, indicated the stage IV (full thicknown or muscle, present on some paperssure ulcer which centimeters. The magnetic pressure ulcer was skin growing in supplications.	with MDS Coordinator #2, on a, she indicated dementia checked on the MDS. record was reviewed on a. Resident #16's diagnoses not limited to, fractured right and depression. mission MDS (minimum data with an assessment reference icated the resident had a less loss with exposed bone, Slough or eschar may be learts of the wound bed) the was 4.5 centimeters by 4.5 lost severe tissue type of any marked epithelial tissue-new	F 278			
	indicated the resideright heel. On 12/1. stage IV, 4.5 by 4.5 black (eschar or ne During an interview Healthcare Unit Manot coded correctly type. 4. Resident #22's reat 9:55 a.m. Resident were not limited anemia, and demensioned to 12/15 to 12/1	ent had a pressure ulcer on his /10 the pressure ulcer was a centimeters and was 90% crotic tissue {dead tissue}). on 1/11/11 at 1:50 p.m., the nager indicated the MDS was for the most severe tissue ecord was reviewed on 1/12/11 ent #22's diagnoses included, I to diabetes mellitus, cancer, ntia.				
		enza immunization education ent, dated 11/3/10, indicated				

F 278 Continued From page 13 the resident had already received the immunization prior to admission. The resident admission physician's orders, dated 11/3/10, indicated an order for Prilosec for gastroesophageal reflux disease (GERD). Resident #22's admission MDS assessment, with an assessment reference date of 11/10/10, indicated, under active diagnoses, GERD was not checked. The MDS indicated the resident had received the influenza immunization at the facility. During an interview on 1/12/11 at 10:33 a.m., MDS coordinator #2 indicated GERD was not marked on the MDS and the resident had not received the influenza immunization at the facility. 3.1–31(g) F 281 SS=D F 281 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 48410 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY PULL TAG FACE CONTINUED FROM INST BE PRECEDED BY PULL TAG F 278 Continued From page 13 the resident had already received the immunization prior to admission. The resident admission physician's orders, dated 11/3/10, indicated an order for Prilosec for gastroesophageal reflux disease (GERD). Resident #22's admission MDS assessment, with an assessment reference date of 11/10/10, indicated, under active diagnoses, GERD was not checked. The MDS indicated the resident had received the influenza immunization at the facility. During an interview on 1/12/11 at 10:33 a.m., MDS coordinator #2 indicated GERD was not marked on the MDS and the resident had no received the influenza immunization at the facility. 3.1-31(g) F 281 F 281 F 281 F 281 Professional Standards 1. The residents #8 and #88 have been evaluated and no negative outcomes were noted from the alleged deficient practice. LPN#7 received a	•	•	155764	B. WING _	a n'amba tandanda.	01/14	1/2011
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 278 Continued From page 13 the resident had already received the immunization prior to admission. The resident admission physician's orders, dated 11/3/10, indicated an order for Prilosec for gastroesophageal reflux disease (GERD). Resident #22's admission MDS assessment, with an assessment reference date of 11/10/10, indicated, under active diagnoses, GERD was not checked. The MDS indicated the resident had received the influenza immunization at the facility. During an interview on 1/12/11 at 10:33 a.m., MDS coordinator #2 indicated GERD was not marked on the MDS and the resident had not received the influenza immunization at the facility. 3.1-31(g) F 281 F 281 F 281 F 281 Professional Standards 1. The residents #8 and #88 have been evaluated and no negative outcomes were noted from the alleged deficient This REQUIREMENT is not met as evidenced			us	11	01 W B7TH AVE		
the resident had already received the immunization prior to admission. The resident admission physician's orders, dated 11/3/10, indicated an order for Prilosec for gastroesophageal reflux disease (GERD). Resident #22's admission MDS assessment, with an assessment reference date of 11/10/10, indicated, under active diagnoses, GERD was not checked. The MDS indicated the resident had received the influenza immunization at the facility. During an interview on 1/12/11 at 10:33 a.m., MDS coordinator #2 indicated GERD was not marked on the MDS and the resident had not received the influenza immunization at the facility. 3.1-31(g) F 281 SS=D The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
by: Based on observation, interview and record review, the facility failed to meet professional standards of quality, related to a nurse (LPN #7) borrowing medications from 1 resident to administer to another resident for 1 (Resident #8) of 10 residents reviewed for medications in a sample of 10 residents and during the observation of the medication pass there were 3 errors in medication administration were observed during 42 opportunities for error in medication administration. This resulted in a	F 281	the resident had all immunization prior The resident admis 11/3/10, indicated a gastroesophageal in Resident #22's adman assessment references and assessment references and an interview MDS coordinator # marked on the MDS received the influer 3.1-31(g) 483.20(k)(3)(i) SEF PROFESSIONAL STATE The services provide must meet profession must meet profession. This REQUIREMED by: Based on observative review, the facility for standards of quality borrowing medication administer to anoth of 10 residents revisample of 10 residents revisample of 10 residents observed during 42 observed observed during 42 observed observed during 42 observed	ready received the to admission. Ision physician's orders, dated an order for Prilosec for reflux disease (GERD). Inission MDS assessment, with erence date of 11/10/10, tive diagnoses, GERD was not indicated the resident had not a immunization at the facility. If on 1/12/11 at 10:33 a.m., indicated GERD was not indicated GERD was not indicated GERD was not in immunization at the facility. If on 1/12/11 at 10:33 a.m., indicated GERD was not in immunization at the facility. If on 1/12/11 at 10:33 a.m., indicated GERD was not in immunization at the facility. If on 1/12/11 at 10:33 a.m., indicated GERD was not in immunization at the facility. If on 1/12/11 at 10:33 a.m., indicated GERD was not in immunization at the facility. If on 1/12/11 at 10:33 a.m., indicated GERD was not in immunization at the facility. If on 1/12/11 at 10:33 a.m., indicated GERD was not in immunization at the facility. If on 1/12/11 at 10:33 a.m., indicated GERD was not indicated GERD was not incident in immunization at the facility. If on 1/12/11 at 10:33 a.m., indicated GERD was not indicated GERD was not incident in indicated GERD was not indicated GERD was not incident incident indicated GERD was not incident indicated GERD was not incident inc		1. The residents #8 a have been evaluated and negative outcomes were from the alleged deficit practice. LPN#7 received coaching and counseling regarding borrowing media. All residents have potential to be effected	and #88 no noted ent d a ication. e the d by the	

No. 7113 P. 20 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION		(X3) DATÉ SURVEY COMPLETED	
			A. BUILDI			
		155764	B. WING		01/14/2011	
	NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			REET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 48410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INPORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281	medication error rasupplemental samp Findings include: 1. During the secon at 4:10 p.m., LPN # dosage of Resident was incorrect. The 13 tablets of the 4 r instead of the 3 mg order on the Januar Administration Rect 1 tab (tablet) p.o. (b. #9 indicated she word dosage of coumadi (emergency drug mobserved to obtain tablet from the pyxis. The January 2011, through 1/11/11, inchad been administration. During an interview ADoN, indicated the Resident #8 had not the pyxis station in 10 During an interview Healthcare Unit Mahave an answer if the 3 mg of coumadi During an interview DoN indicated she was a gotten the 3 mg of coumadi During an interview DoN indicated she was a gotten the 3 mg	d medication pass on 1/12/11 9 was observed to notice the #8's coumadin (blood thinner) medication punch card helding (milligrams) dosages. Resident #8's physician's y 2011 MAR (Medication ord) indicated "coumadin 3 mg y mouth) qd (everyday)." LPN puld need to obtain the correct in from the pyxis station from the pyxis station achine). LPN #9 was a 1 mg tablet and a 2 mg is station for the resident. MAR was initialed from 1/6/11 dicating the 3 mg of coumadin from December or January. on 1/12/11 at 5:00 p.m., the pharmacy had stated the received any coumadin from December or January. on 1/12/11 at 5:10 p.m., The mager indicated she did not the resident had received 4 mg in for the six days. on 1/12/11 at 5:15 p.m., The was not aware if the resident of coumadin as ordered.	F 28	F-281 Continued 3. The licensed staff been in- serviced on the policy on "no borrowing" medications and the crus medications. 4. The DHS or designe conduct medication pass with 100% of the license and appropriate education coaching and counseling initiated based on the recepeat reviews will be countil 100% compliance is achieved. Random medicat observations will be compat least monthly for 3 methereafter, then quarter on the outcomes and the Committee recommendations.	campus of hing of e will review d staff n or esults. onducted ion pass pleted onths, ly based QA	
	DoN indicated she	was not aware if the resident j of cournadin as ordered.			,	

Jan. 27. 2011 8:57AM Spring Mill Health Campus

No. 7113

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CÉIA IDENTIFICATION NUMBER:	1` ′	-	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		d state (B. WING		-		
11115 AF -		155764	1			01/14	1/2011
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	us		10	EET ADDRESS, CITY, STATE, ZIP CODE 01 W 87TH AVE ERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 15	F2	81			
	5:15 p.m. Residen	rd was reviewed on 1/12/11 at t #8's diagnoses included, but multiple sclerosis and history posis.					
	Hold 4 mg Coumad	dated 1/5/11, indicated "1, lin today. 2. D/C (discontinue) Coumadín 3 mg p.o. qd. 4. 1 week. (sic)."					
	#7 indicated she hat tablets from anothe half to administer the #7 indicated she had 1/9. LPN #7 indicated	on 1/12/11 at 5:15 p.m., LPN ad borrowed 6 mg Coumadin or resident and "cut" them in the 3 mg to the resident. LPN ad done this twice on 1/7 and ted she did not know why she nedication from the pyxis					
	Healthcare Unit Ma	1/12/11 at 5:50 p.m., the nager indicated she could not ident the medication had been					
	indicated "Medica	d "Medication eral Guidelines," dated 3/1/07, itions supplied for one resident ered to another resident"					
,	in medication admit during 42 opportuni	eation pass there were 3 errors nistration were observed ties for error in medication resulted in a medication error					
	1/12/11 at 9:18 a.m	on pass observation on through 9:25 a.m., LPN #7 aring medication for resident					

Jan. 27. 2011 8:57AM Spring Mill Health Campus

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 7113 P. 22 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
· · · · · · · · · · · · · · · · · · ·		155764	B. WING		- 01/*	i4/2011	
	ROVIDER OR SUPPLIER MILL HEALTH CAMI	PUS		STREET ADDRESS, CITY, STATE, 101 W 87TH AVE MERRILLVILLE, IN 46410	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IĎ PREFI TAG		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 281	#88. LPN #7 crusi (stomach medicati potassium chloride milliequivalents. L Cardizem CD (can and placed them in the medications to During an interview #7 indicated she norush medication. a do not crush list medication cart. Resident #88's recepize a.m. Resider were not limited to congestive heart for the resident's addited 1/11/11, lack to crush the reside A "medications not by LPN #1 on 1/12 potassium chloride be crushed due to The Nursing Spect 2010 indicated: Cardizem CD (externations and state of the condens of the condens of the condens of the cardizem CD (externations of the cardizem CD (externations). "Instruct tablets whole and in the carding" Instruct tablets whole and in the cardizer carding" Instruct tablets whole and in the carding" Instruct tablets whole and in the carding "Instruct tablets whole and in the carding	hed the tablets of Prilosec on) 20 milligrams and (supplement) 20 PN #7 opened the capsule of diac medication) 180 milligrams in yogurt and then administered the resident. If you not	F 2	281			

PRINTED: 01/21/2011 FORM APPROVED

<u> </u>	TO LOIT MEDIOMILE	COMPONIO OFWAIOFO				OMB NO.	. 0938-0391
	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
·		155764	e. wir	NG_		01/1	4/2011
NAME OF F	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAMP	ÚS		1	01 W 87TH AVE	•	
	, · .			N	MERRILLVILLE, IN 48410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION S) TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		II D BE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 17	F:	281		******	
	#1 indicated the pot should not have be	tassium chloride and Prilosec en crushed. She indicated the ided release capsule should					
	3.1-35(g)(2)				-		
F 282 SS=D		RVICES BY QUALIFIED ARE PLAN	F	282	F-282 Following Care Plants 1. Residents #3, #5,		
	The services provided or arranged by the fac				#22, #27, and #29 were	1107	
	must be provided by	y qualified persons in			evaluated at the time of	= SILTVAV	
	accordance with each resident's written care.				and no negative outcomes		
	Care.			:	noted. Medication error	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
					circumstance reports wer	-e	
		IT is not met as evidenced			completed and the nurses		
	by: Based on observation	on, record review, and		i	involved received coachi		
	interview, the facility	failed to ensure physician's			counseling.	5	
	orders and resident	s plans of care were followed,			2. Current resident's	care i	
	related to a treatme	nt to prevent pressure ulcers			plans will be reviewed f		
		s, for 6 of 10 resident's ng physician's orders and			interventions in particu		
	plans of care in a sa	imple of 10. (Residents #3,			regards to safety and sk	- 1	
}	#5, #8, #22, #27, an	d #29)			ensure they are on the C		
	Findings include:				assignment sheet and		
	· nongo mondo.			İ	implemented.		
	1. Resident #27's re	ecord was reviewed on			3. The staff will be	in	
	1/11/11 at 10:37 a.n	n. Resident #27's diagnoses			serviced on the interven		
ļ	failure, hypertension	ot limited to, congestive heart , and benign prostatic		ļ	to prevent falls, skin		ļ
	hypertrophy (enlarge	ed prostate). Resident #27's			maintenance, and medicat	ion	
	original admission d				administration.		
	apply granulex (topic	ated 10/19/10, indicated to cal medication to prevent eft heel daily to prevent				,	

No. 7113 P. 24

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PRÓVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SL COMPLE	
		155764	B. WING _		01/14	W2011
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS		1	REET ADDRESS, CITY, STATE, ZIP CODE 01 W 87TH AVE BERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	(X5) COMPLETION DATE
F 282	A MAR (Medication 10/1/10 through 10/1/10 through 10/1/10 granulex to left hee The following dates 10/25, and 10/26, windicating the medication the record lacked of medication was not During an interview a.m., she indicated delivered on 10/21, pharmacy. I don't withose days." 2. During the initial 10:05 a.m. Resident her wheelchair in the tab alarm was continued the clip to the alarm CNA #5 who was sindicated the clip were sident's aweater. Resident #5 was obtained to left the sident #5 was obtained the clip were sident #5 was obtained the clip were sident #5 was obtained the sident #5 was obtained the clip were sident #5 was obtained the clip were sident #5 was obtained the clip was obtained the clip were sident #5 was obtained the clip were sident #5 was obtained the clip was obtained the clip was a sident #5 was obtained #5 was obtaine	Administration Record), dated /31/10, indicated apply I daily to prevent breakdown. 1, 10/20, 10/22, 10/23, 10/24, were initialed and circled cation was unavailable. I documentation as to why the available. I with LPN #1, on 1/12/11 at 11 "I wrote granulex to be because I contacted the know why it wasn't here for tour on 1/10/11 beginning at at #5 was observed sitting up in the dining room. The resident's the lected to the wheelchair and in was laying on her sweater. I tanding by the resident, as not connected to the	F 282	4. The DHS or design monitor care plan inter in regards to skin and at least daily until 10 compliance is achieved weeks then at least twi weekly for 3 months and less than quarterly. The designee will conduct medication pass review 100% of the licensed stappropriate education of coaching and counseling initiated based on the Then repeat reviews will conducted until 100% cois achieved. Random med pass observations will completed at least mont. 3 months, thereafter, the	ventions safety 0% for 3 ce then no e DHS or with aff and r results. 1 be mpliance ication be hly for hen	
	room. The clip to the hanging down the backped to the resident clipped to the clip	(11 at 9:12 a.m., in the dining ne resident's alarm was each of the wheelchair and not ent. CNA #6, who was in the ed the clip was supposed to be ent.		quarterly based on the and the QA Committee recommendations.	outcomes	2/13/11
,	10:05 a.m. Resider	d was reviewed on 1/11/11 at nt #5's diagnoses included, but Alzheimer's Disease, difficulty eoporosis.				
	A care plan for at ris	sk for falls, dated 12/06/10,				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BÚI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		155764	B. Wil	۱G		01/14	4/2011
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	US	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	,	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XS) COMPLETION DATE
F 282	indicated "person 3. Resident #29's r 1/10/11 at 12:10 p.r included, but were rosteoarthritis, and he Resident #29's care indicated the reside interventions includ "appropriate footwe". Resident #29 was op.m., 12:56 p.m., ar second floor dining any shoes. During an interview Healthcare Unit Mawas not wearing an resident's fall care pto wear appropriate 4. Resident #22's r 1/12/11 at 9:55 a.m included, but were rome cancer, anem A hospital physiciar indicated "dexametistimulates bone mainflammation) 4 mg mouth dailyx (time	al alarm to chair." record was reviewed on m. Résident #29's diagnoses not limited to, dementia, hypertension. e plan, dated 12/14/10, ent was at risk for falls. The ed, but were not limited to, ear." observed on 1/10/11 at 12:23 and 1:39 p.m., sitting in the room with socks on without on 1/10/11 at 1:40 p.m., the mager indicated the resident y shoes. She indicated the olan indicated the resident was a footwear. ecord was reviewed on a. Resident #22's diagnoses not limited to diabetes mellitus, ia, and dementia. also order, dated 11/3/10, hasone (a medication which arrow and reduces (milligrams)Take 40 mg by es) 4 days po (orally)every es: Finished cycle Nov	F:	282			
	The resident's admidated 11/3/10, indicated 40 mg every of	ission physician's orders, cated dexamethasone 4 mg day times four days, the to be administered on					

Jan. 27. 2011 8:57AM Spring Mill Health Campus

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 7113 P. 26 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		. 155764	B. WING			01/14/2011		
	ROVIDER OR SUPPLIER			110	REET ADDRESS, CITY, STATE, ZIP CODE 01 W 87TH AVE MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFIÇIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 282	Record), dated 12 received the dexar 12/1/10, 12/2/10, 12	R (Medication Administration /10, indicated the resident methasone as ordered on 12/3/10, and 12/4/10. R, dated 1/11, indicated en 4 mg tablets were to be /1/11, 1/2/11, 1/3/11 and 1/4/11. of documentation to indicate the be administered on 1/4/11. Inedication punch card on the card had 40 four milligram he pharmacy had delivered the e were 33 tablets left in the en on 1/12/11 at 11:10 a.m., the pharmacy had sent 80 imethasone in November. In on 1/12/10 at 11:30 a.m., she did not know why there dexamethasone left if the en given as ordered.	F	282				
	5. Resident #3's re	cord was reviewed on 1/10/11			I			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 7113 P. 27
PRINTED: 01/21/2011
FORM APPROVED
OMB NO. 0938-0391

	10 1 OIL WILLDION IL	OF INCESSION OF LAND			· · · · · · · · · · · · · · · · · · ·	VIND NO.	0900-0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155764	B. WING			01/14/2011	
	ROMDER OR SUPPLIER MILL HEALTH CAMP	us		10	REET ADDRESS, CITY, STATE. ZIP CODE 01 W 87TH AVE		
				IA.	MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	Continued From pa	ae 21	F:	282			
	at 12 p.m. Resider	nt #3's diagnoses included, but congestive heart failure,	,	-V-			
		ician's order recapitulation, ad the resident had an allergy nedication).					
		dated 1/4/11, indicated milligrams) every 6 o (hours)					
		R, dated 1/11, indicated the ed the Tramadol on 1/7/10.					
	DoN (Director of No	on 1/10/11 at 12:30 p.m., the urses) indicated the nurses for allergies before giving					
	Nurse Consultant in have caught the all	on 1/10/11 at 12:35 p.m., the ndicated the pharmacy should ergy and called the facility. urses should have caught the					
	at 4:10 p.m., LPN # dosage of Resident was incorrect. The 13 tablets of the 4 r	id medication pass on 1/12/11 9 was observed to notice the #8's coumadin (blood thinner) medication punch card held ng (milligrams) dosages					
	order on the Janual Administration Reco 1 tab (tablet) p.o. (b #9 indicated she wo dosage of coumadi (emergency drug m	Resident #8's physician's ry 2011 MAR (Medication prof) indicated "cournadin 3 mg by mouth) qd (everyday)." LPN puld need to obtain the correct in from the pyxis station pachine). LPN #9 was a 1 mg tablet and a 2 mg					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 7113 P. 28
PRINTED: 01/21/2011
FORM APPROVED
OMB NO. 0938-0391

155764 B. WING	4/2011
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE	
,,	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 Continued From page 22 tablet from the pyxis station for the resident. The January 2011, MAR was initiated from 1/6/11 through 1/11/11, indicating the 3 mg of coumadin had been administered as ordered by the physician. At on 1/12/11 at 5:00 p.m., the ADoN, indicated the pharmacy had stated Resident #8 had not received any coumadin from the pyxis station in December or January. The Healthcare Unit Manager, indicated at 5:10 p.m., she did not have an answer if the resident had received 4 mg or 3 mg of coumadin for the six days. The DoN at 5:15 p.m., indicated she was not aware if the resident had gotten the 3 mg of coumadin as ordered. The DoN indicated "guess not." Resident #8's record was reviewed on 1/12/11 at 5:15 p.m. Resident #8's diagnoses included, but were not limited to, multiple sclerosis and history of deep vein thrombosis. A physician orders recapitulation, dated January 2011, indicated "Coagucheck (test for blood clotting) every Wednesday, keep between 2-3 notify MD (doctor) if <2 or >3." A resident coag testing record indicted the resident's level was 3.5 on 1/5/11 and on 1/12/11 was 1.8 A physician's order dated 1/5/11, indicated "1. Hold 4 mg Coumadin 3 mg p.o. qd. 4.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 7113 P. 29
PRINTED: 01/21/2011
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OMB NO. 0938-0391

CENTER	(S FOR MEDICARE	& MEDICAID SERVICES				<u>OMB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
	·	155764	B. WIN	IG.		01/14	¥/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAMP	US			MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	Continued From pa	ige 23	F	282	2		,
	Recheck q (every)	1 week. (sic)."					
		none order, dated 12/17/10 ent was to start 4 mg of ay.					
	medication punch of from the pharmacy card contained 30 t	2/11 at 4:10 p.m., of a card, indicated it was received on 12/17/10. The medication tablets of Coumadin 4 were still 13 tablets left in the			·	:	
	Coumadin 4 milligra administered on 12	R, dated 12/10, indicated the am tablets had been 1/17/10 though 12/31/10 (15 on should have been					
	Coumadin 4 milligra	R. dated 1/11, indicated the am tablets had been 1/4/11 (4 tablets should tered).					
	been administered have been 11 table	tablets which should have to the resident. There should ts left of the Coumadin 4 edication punch card, not 13				·	
	#7 indicated she hat tablets from anothe half to administer th #7 indicated she ha 1/9. LPN #7 indicated	on 1/12/11 at 5:15 p.m., LPN ad borrowed 6 mg Coumadin er resident and "cut" them in ne 3 mg to the resident. LPN ad done this twice on 1/7 and ted she did not know why she nedication from the pyxis					

No. 7113 P. 30 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,				
	155764	B. WING	3 <u>_</u>	01/1	4/2011	
	us	,	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		V. 3.0 11	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFÍX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
During interview on Healthcare Unit Ma determine what res obtained from. During an interview ADoN indicated the the pharmacy had rethe 3 mg Coumadir	1/12/11 at 5:50 p.m., the nager indicated she could not ident the medication had been on 1/12/11 at 7:08 p.m., the facility pharmacy had stated never received the order for and needed to have the order		82			
Each resident must provide the necessar or maintain the high mental, and psycho	EING receive and the facility must ary care and services to attain test practicable physical, social well-being, in	F 36	Achieve Highest St. 1. Alleged deficerected at the transfer for residents #3 aresidents have been and no negative or noted.	candard of Care ciencies were cime of survey and #11. Both en evaluated atcomes were		
by: Based on observation review, the facility facare and services represent with a diagrailure and a resider stage renal disease restrictions for 2 of prestrictions in a samulation and the samulation in the same samulation in the samulation in th	on, interview, and record ailed to provide the necessary elated to failure to monitor a nosis of congestive heart at with a diagnosis of end, who were both on fluid 2 residents with fluid aple of 10. (Residents #3 and		evaluated and corrected their monitoring mappropriate. Physically will be compared to for all current resupdates will be made necessary. 3. The campus has flow sheet to make with the number of the compared to the compared	rections to made as cian's orders co menu cards esidents. de as mas implemented mitor fluid mrses MAR. be in-serviced		
1. Resident #3 was	observed during the initial tour		_	i i		
	Continued From pa During interview on Healthcare Unit Ma determine what res obtained from. During an interview ADoN indicated the the pharmacy had r the 3 mg Coumadir faxed to the pharma 3.1-35(g)(2) 483.25 PROVIDE C HIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psycho accordance with the and plan of care. This REQUIREMEN by: Based on observative review, the facility fa care and services re resident with a diag failure and a resider stage renal disease restrictions in a sam #11) Findings include:	TIDENTIFICATION NUMBER: 155764 ROVIDER OR SUPPLIER MILL HEALTH CAMPUS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 During interview on 1/12/11 at 5:50 p.m., the Healthcare Unit Manager indicated she could not determine what resident the medication had been obtained from. During an interview on 1/12/11 at 7:08 p.m., the ADON indicated the facility pharmacy had stated the pharmacy had never received the order for the 3 mg Cournadin and needed to have the order faxed to the pharmacy. 3.1-35(g)(2) 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility falled to provide the necessary care and services related to failure to monitor a resident with a diagnosis of congestive heart failure and a resident with a diagnosis of end stage renal disease, who were both on fluid restrictions for 2 of 2 residents with fluid restrictions in a sample of 10. (Residents #3 and #11)	ROVIDER OR SUPPLIER MILL HEALTH CAMPUS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 During interview on 1/12/11 at 5:50 p.m., the Healthcare Unit Manager indicated she could not determine what resident the medication had been obtained from. During an interview on 1/12/11 at 7:08 p.m., the ADON indicated the facility pharmacy had stated the pharmacy had never received the order for the 3 mg Cournadin and needed to have the order faxed to the pharmacy. 3.1-35(g)(2) 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary care and services related to failure to monitor a resident with a diagnosis of congestive heart failure and a resident with a diagnosis of end stage renal disease, who were both on fluid restrictions for 2 of 2 residents with fluid restrictions in a sample of 10. (Residents #3 and #11) Findings include:	ROVIDER OR SUPPLIER MILL HEALTH CAMPUS SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 24 During interview on 1/12/11 at 5:50 p.m., the Healthcare Unit Manager indicated she could not determine what resident the medication had been obtained from. During an interview on 1/12/11 at 7:08 p.m., the ADON indicated the facility pharmacy had stated the pharmacy had never received the order for the 3 mg Cournadin and needed to have the order faxed to the pharmacy. 3.1-35(g)(2) 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary care and services related to failure to monitor a resident with a diagnosis of congestive heart failure and a resident with a diagnosis of of end stage renal disease, who were both on fluid restrictions for 2 of 2 residents with fluid restrictions in a sample of 10. (Residents #3 and #11) Findings include: 1. Resident #3 was observed during the initial tour.	ROVIDER OR SUPPLIER MILL HEALTH CAMPUS SUMMARY STATEMENT OF DESICIENCIES (EACH DEFICIENCY STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410 SUMMARY STATEMENT OF DESICIENCIES (EACH DEFICIENCY STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410 SUMMARY STATEMENT OF DESICIENCIES (EACH DEFICIENCY STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410 SUMMARY STATEMENT OF DESICIENCIES OF MERRILLVILLE, IN 46410 SUMMARY STATEMENT OF DESICIENCIES OF MERRILLVILLE, IN 46410 CONTINUED FROM PAGE 24 Deficiency or List of the Consection of the Con	

No. 7113 P. 31 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
			A BUI	LDIN	G	OOMFEE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		155764	B, WIN	[G_		01/14	4/2011
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	us		10	EET ADDRESS, CITY, STATE, ZIP CODE D1 W 87TH AVE IERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 309	on 1/10/11 beginning. The resident was of wheelchair in her recups sitting on the lempty and the other cups held 120 cc (condicated the resident #3 was obtoom, sitting up in hear lunch tray. The cc) glass of water of indicated 66 cc per a 1400 cc fluid restrict indicated 1/2 cup (1 (120) of coffee. At 1:16 p.m., the refilled with coffee, the usually only drinks a DoN indicated she was on the resident had received on her tray. At 1:24 p.m., the Doff the resident was of the residen	bserved sitting up in her born. There were two plastic pedside table, one cup was r was half full. The plastic public centimeters). LPN #2 and's weight was stable. Discreved on 1/10/11 at 1:05 are wheelchair in her room with tray had an eight ounce (240 in it. The resident's menu card shift and the resident was on riction. The menu card 20 cc)of juice and 1/2 cup asident had a coffee cup (240) at a half a cup of the coffee. The did not know why the 66 cc is menu card. Detary manager indicated the edit on much fluid from dietary and intake and output record (I was on an IV (intervenous ething." Detary (Registered Dietician) to scrap this and start all	F	509	F-309 Continued 4. The DHS or design review the fluid intake sheets at least 5 days until 100% compliance i achieved for 3 weeks the least twice per week for months and then quarter the ongoing QA process. Director of Dining Services designee will review mentickets to physician's monthly and review trendmonthly QA meeting.	flow per week s en at or 3 ly with The ices or nu orders	2/13/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE S	
7.1101 0 41 0	CONTROLL	IDENTITION NUMBER.	A. BUILDII	NG	COMPLI	CIED
•		155764	B. WING_	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	01/1	4/2011
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COI		
SPRING	MILL HEALTH CAMP	us		101 W 87TH AVE MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 26	F 309			
	12:00 p.m. Resider were not limited to,	d was reviewed on 1/10/11 at nt #3's diagnoses included, but congestive heart failure, sufficiency, pleural effusion, ma.				
i		dated 12/12/10, indicated ction, 400 cc per shift, 66 cc				
	"NAS (no added sa	nent, dated 12/03/10, indicated It) 1400 cc FR (fluid nursing per shift & 66 cc per				į.
	2010, lacked documenthe following meals Breakfast: 11, 12, 1 Lunch: 9, 11, 15, 16, 29, and 30.	fluid detail report for December nentation of the fluid intake for , on these dates: 5, 16, 20, 24, and 26. 6, 17, 18, 19, 20, 24, 26, 27, , 14, 16, 20, and 28.				
		nd 9. , 9, and 10.				1900
	DoN indicated the s	on 1/12/11 at 11:30 a.m., the taff had done good tracking ecember but not January.				
		AR (Medication Administration ne nurses were initialing the ing 400 cc per shift.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 7113 P. 33 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155764	a. wi	1G	 	01/14	W2011
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	us		10	EET ADDRESS, CITY, STATE, ZIP CODE DI W 87TH AVE ERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ŲLD BĘ	(X5) COMPLETION DATE
F 309	A care plan for "pot nutritional and/or flu 12/14/10 and revise rd for decline in food A care plan, dated indicated "Monitor gain/loss to MD (mater at bedside A care plan, dated decreased cardiac restriction as orders. The DoN indicated nurses keep track a shift by writing note shift if the resident. The DoN indicated 2. Resident #11's 1/12/11 at 9:05 a.m included, but were disease, dialysis, at A physician's order "1200 ml (milliliters). A January 2011 Materiction." The faresident was received a 1/12/11 dietary con a 1000 cc fluid resident diseases. The distance of the faresident was received a 1/12/11 dietary con a 1000 cc fluid resident diseases.	rential for/alteration in uid balance status" dated at 1/4/11 indicated "consult diffluid intake" 11/11/10, for dehydration, weight as ordered and report edical doctor)Provide fresh " 12/13/10, for at risk for output indicated "fluid ed." on 1/12/11 at 10:20 a.m., the of the resident's fluids on their is and telling the oncoming stays in her fluid restriction. the nurses then sign the MAR. record was reviewed on a. Resident #11's diagnoses not limited to, end stage renal and hypertension. dated 12/15/10, indicated fluid restriction." AR, indicated "1200 ml fluid cility nurses were initialing the ring 1200 ml fluids per day. ard, indicated the resident was	F	309			
	mouth) intake wt (s			ļ			

No. 7113 P. 34

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	U 172 1328 I I
FORM A	PPROVED
OMB NO. (0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		155764	B. WING _		01/14/2011		
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	us		REET ADDRESS, CITY, STATE, ZIP CODE 161 W 87TH AVE MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PŘEFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION'SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE 9	(X5) COMPLETION DATE	
F 309	A dietary progress "reflecting of rena (arrow pointing dow (treatment) possibly being a dialysis pt (A care plan, dated resident was non-crestriction. A facility meal and 2010, lacked docur the following meals Breakfast: 8, 10, 12 30, and 31. Lunch: 8, 9, 11, 15 29. Dinner: 7, 8, 10, 13 A facility meal and 2011, lacked docur the following meals Breakfast: 1, 3, 5, 7 Lunch: 1, 3, 5, 6, 7 Dinner: 2, 4, and 8. A facility policy, dat Fluid Restriction," in provided within the the Dietary Departr breakdown by meal Department shall re-	note, dated 12/20/10, indicated al dx (diagnosis) decrease vn) na+ (sodium) no diuretic tx y r/t (related to) excess fluid r/t patient)" 12/23/10, indicated the ompliant with the fluid fluid detail report for December mentation of the fluid intake for on these dates: 2, 15, 16, 17, 20, 24, 27, 29, 3, 16, 17, 20, 22, 24, 26, and 4, 14, 16, 20, 22, 24, and 28. Ifluid detail report for January mentation of the fluid intake for on these dates: 7, 8, 9, and 10. Indicated "to ensure fluids are physician order guidelines3. Inent shall record established all on tray card. 4. The Nursing ecord established breakdown	F 309				
	and/or in the Care intake of fluid on th Measurements Pro shall be reviewed a	ication Administration Record Tracker system. 5. Record e Care Tracker system gram. 6. Fluid consumption each shift to determine sary in the fluid intake of the					

No. 7113 P. 35 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR MEDICARE	& MEDICAID SERVICES						
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) D				(3) DATE SURVEY COMPLETED	
		155764	B. WIN	IG		01/1	4/2011	
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	US		10	EET ADDRESS, CITY, STATE, ZIP CODE D1 W 87TH AVE ERRILLVILLE, IN 46410	1—- <u> </u>	1.120 11	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	established fluid ne 3.1-37(a)	riction in order to meet their eds"		309	F-314 Pressure Ulcers			
	resident, the facility who enters the facil does not develop p individual's clinical of they were unavoidal pressure sores received to promote prevent new sores. This REQUIREMENT by: Based on observation interview, the facility preventative treatmere pressure ultrisk for developing 10 residents. (Resident #27's reat 10:37 a.m. Resident were not limited.)	rehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that lible; and a resident having eives necessary treatment and a healing, prevent infection and from developing. IT is not met as evidenced on, record review, and y failed to ensure a ent was done as order to cers for 1 of 10 residents at pressure ulcers in a sample of	F		F-314 Pressure Ulcers 1. Resident #27 never pressure ulcer to his left. The Granulex treatment had iscontinued. 2. The current residence audited for similar or and ensure the appropriate preventive measures are is and available. 3. The licensed staff in-serviced on the appropriate preventions for prevent pressure ulcers. 4. The DHS or designed monitor the Treatment Administration Record's (at least 5 days per week 100% compliance is achieved then twice per week for 3 and then quarterly as particle ongoing QA process.	theel. as been ats will aders ae an place will be briate cion of a will TAR)'s until and months	2/13/11	
	admission date was A care plan, dated for alteration in skin	Resident #27's original 10/19/10. 10/22/10, indicated potential integrity, the interventions not limited to, administer					·	

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 85XV11

Facility (D; 010739

If continuation sheet Page 30 of 44



Jan. 27. 2011 8:59AM Spring Mill Health Campus

DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 7113 P. 36 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES					0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTI	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	URVEY
		155764	B. WI	NG_	· .	01/1	4/2011
	PROVIDER OR SUPPLIER MILL HEALTH CAMP			10	REET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	preventative treatm Admission orders, apply granulex (top pressure ulcers) to breakdown. A MAR (Medication 10/1/10 through 10 granulex to left hee The following dates 10/25, and 10/26, windicating the medication was not During an observative resident #27's heel. During an interview a.m., she indicated delivered on 10/21, pharmacy. I don't intose days." 3.1-40(a)(1) 483.25(m)(1) FREE RATES OF 5% OR	dated 10/19/10, indicated to pical medication to prevent of left heel daily to prevent breakdown, so 10/20, 10/22, 10/23, 10/24, were initialed and circled lication was unavailable. Indicated apply lication			F-332 Medication Error Resident #88 was evaluat the time of the survey a negative outcomes were n	and no	
	by: Based on observati	NT is not met as evidenced tion, interview, and record failed to ensure a medication					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8SXV11

Facility ID: 010739

If continuation sheet Page 31 of 44



No. 7113 P. 37 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PRÓVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155764	B. WING_			
NAME OF F	ROVIDER OR SUPPLIER	100764	l		01/1	4/2011
	MILL HEALTH CAMP	us .	1	REET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU GROSS-REFERENCED TO THE APPRI DEFICIENCY)	II D BE	(X5) COMPLETION DATE
F 332	error rate of less the	ge 31 an 5% for 1 of 5 supplemental Resident #88) observed	F 332	F-332 Continued 2. All residents have	the	
	receiving medications. 3 errors in medication administration were observed during 42 opportunities for error in medication administration. This resulted in a medication error rate of 7.14%. Findings include:			potential to be affected alleged deficient practi	ce.	
				3. The licensed staff be in-serviced on the professional standards of		,
				medication administration emphasis on medication c	n with	
	1/12/11 at 9:18 a.m was observed prepa #88. LPN #7 crusha (stomach medicatio potassium chloride milliequivalents. LF Cardizem CD (card and placed them in the medications to t	N #7 opened the capsule of lac medication)180 milligrams yogurt and then administered he resident.		and the appropriate way to obtain and administer medications. 4. The DHS or designed conduct medication pass with 100% of the licensed and appropriate education coaching and counseling	e will review d staff	
	During an interview on 1/12/11 at 9:35 a.m., LPN #7 indicated she needed a physician's order to crush medication. She indicated she did not have a do not crush list for medications on her medication cart.	÷	initiated based on the re Then repeat reviews will conducted until 100% comp is achieved. Random medic pass observations will be	be oliance cation		
	9:28 a.m. Resident	rd was reviewed on 1/12/11 at #88's diagnoses included, but gastrointestinal bleed and ure.		completed at least monthl 3 months thereafter, ther quarterly based on the ou and the QA Committee	y for	2/13/11
		ssion physician's orders, ad documentation of an order t's medications.		recommendations.		2/13/11
	by LPN #1 on 1/12/1	o be crushed" list, provided 1 as current, indicated and Cardizem CD were not to				

No. 7113 P. 38
PRINTED: 01/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER AND PLAN OF CORRECTION (DENTIFICATION)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' '	(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE SURVEY COMPLETED	
		155764	B. WIN	NG		01/1	4/2011	
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	us		10	EET ADDRESS, CITY, STATE, ZIP CODE D1 W 87TH AVE IERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-RÉFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 333 SS=D	be crushed due to to the Nursing Spectr 2010 indicated: Cardizem CD (exter 351-353, indicated patient to swallow exhole and not to crediter to swallow exhole and not to crediter to swallow exhole and not to crediter whole and not not have been and indicated the possibulid not have been oper 3.1-25(b)(9) 483.25(m)(2) RESII SIGNIFICANT MEDITORIES The facility must enany significant med and significant med to residents review, the facility were free of significant review, the facility were free of significant med to residents review errors in a sample of #8, and #22) Findings include: 1. Resident #22's residents review errors in a sample of #8, and #22's resident #22's resid	ime release formulations. Tum Drug Handbook, dated Inded release capsule), pages "Patient teaching *Instruct extended-release-capsules ush or chew them" 7-858, indicated "Patient patient to swallow capsules or of to chew or crush them" In 1/12/11 at 9:38 a.m., LPN tassium chloride and Prilosec en crushed. She indicated the inded release capsule should ined. DENTS FREE OF DERRORS sure that residents are free of ication errors. In is not met as evidenced on, record review, and of failed to ensure residents' and medication errors for 3 of ed for significant medication of 10 residents. (Residents #3, ecord was reviewed on		332	F-333 Significant Med E 1. Residents #22, #3 #8 were evaluated at th of survey with no indic of negative outcomes. 2. All residents hav potential to be affecte the alleged deficient practice.	, and e time ation e the		
		ecord was reviewed on . Resident #22's diagnoses						

No. 7113 P. 39 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A BUILDING			
155764		B. WING		01/14/2011		
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 333	Continued From page 33 included, but were not limited to diabetes mellitus, bone cancer, anemia, and dementia.		F 333	F-333 Continued The licensed staff	will be	
	A hospital physician indicated "dexametistimulates bone mainflammation) 4 mg mouth dailyx (time 28 days. Instruction (November) 3rd sta The resident's admit dated 11/3/10, indicated 40 mg every demodication was due 12/1/10. The resident's MAR Record), dated 12/1/10, The resident's MAR dexamethasone ten administered on 1/1 There was a lack of medication was to b Observation of a medication. There is tablets in it when the medication. There is card. During an interview LPN #7 indicated the	a's order, dated 11/3/10, masone (a medication which rrow and reduces (milligrams)Take 40 mg by es) 4 days po (orally)every s: Finished cycle Nov rt December 1st." ssion physician's orders, ated dexamethasone 4 mg lay times four days, the eto be administered on (Medication Administration 0, indicated the resident ethasone as ordered on		in-serviced on the professtandards of medication administration with emphased appropriate way to obtain administer medications. The DHS or designed conduct medication pass with 100% of the licensed and appropriate education coaching and counseling initiated based on the restricted until 100% compiss achieved. Random medical pass observations will be completed at least monthly months thereafter, then quarterly based on the out and the QA Committee recommendations.	asis on the n and will review d staff n or esults. be cation en are sy for 3	2/13/11
	During an interview	on 1/12/10 at 11:30 a.m.,				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 7113 P. 40

PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY TED
	•	155764	B. Wil	NG_		01/1	4/2011
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	us		1	REET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	QŲLD BE	(X5) COMPLETION DATE
F 333	LPN #7 indicated s were 33 tablets of medication had been 2010, pages 331-3 "dexamethasone patient not to stop A "Medication error dated 1/12/11, rece Manager indicated 1/1/11-1/4/11. The 2. Resident #3's reat 12 p.m. Resident were not limited to, arthritis, and hyper Resident #3's physician's order "Tramadol (pain a needed for pain The resident's MAI resident had received Don (Director of N should be checking medications.	he did not know why there dexamethasone left if the en given as ordered. rum Drug Handbook, dated 33, indicated Patient teachingcaution taking drug abruptly" r circumstance investigation, eived from the Healthcare Unit the date of the error wrong dose was administered. cord was reviewed on 1/10/11 at #3's diagnoses included, but congestive heart failure, tension. ician's order recapitulation, ed the resident had an allergy medication). c, dated 1/4/11, indicated milligrams) every 6 o (hours) c, dated 1/11, indicated the red the Tramadol on 1/7/10. If on 1/10/11 at 12:30 p.m., the urses) indicated the nurses of for allergies before giving	F	333			
	have caught the all	ndicated the pharmacy should ergy and called the facility.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155764	B. WING		01/1	4/2011
	ROVIDER OR SUPPLIER	us	10	EET ADDRESS, CITY, STATE, ZIP CODE IT W 87TH AVE ERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 333	allergy also. 3. During the seco at 4:10 p.m., LPN # dosage of Resident was incorrect. The 13 tablets of the 4 trinstead of the 3 mg order on the Janua Administration Rec 1 tab (tablet) p.o. (the findicated she we dosage of coumadi (emergency drug mobserved to obtain tablet from the pyxit The January 2011, through 1/11/11, included been administed physician. At on 1/12/11 at 5:00 the pharmacy had a received any coumber or January The Healthcare Unip.m., she did not had a received 4 mg six days. The DoN at 5:15 p. aware if the resider	nd medication pass on 1/12/11 19 was observed to notice the 1 #8's coumadin (blood thinner) 1 medication punch card held 1 mg (milligrams) dosages 1. Resident #8's physician's 1 ry 2011 MAR (Medication 1 ord) indicated "coumadin 3 mg 1 mg mouth) qd (everyday)." LPN 1 could need to obtain the correct 1 from the pyxis station 1 nachine). LPN #9 was 1 mg tablet and a 2 mg 1 mg tablet and a	F 333	VET TOTAL TO		
	5:15 p.m. Resident	d was reviewed on 1/12/11 at t#8's diagnoses included, but multiple sclerosis and history		· .		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155764	B. WIN	G		01/14	W2011
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	us		10	EET ADDRESS, CITY, STATE, ZIP CODE IN W 87TH AVE ERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		ULD BE	(X5) COMPLETION DATE
F 333	2011, indicated "Coclotting) every Wednotify MD (doctor) in A resident coag test resident's level was was 1.8 A physician's order Hold 4 mg Coumadour 4 mg Coumadour 4 mg Coumadour 4 mg Coumadour 5 telepholicated the reside Coumadour 6 every day Coumadour 6 from the pharmacy card contained 30 to milligrams. There is punch card. The resident's MAF Coumadour 4 milligrams administered on 12 tablets of medication administered.).	recapitulation, dated January bagucheck (test for blood linesday, keep between 2-3 f <2 or >3." Sting record indicted the s 3.5 on 1/5/11 and on 1/12/11 dated 1/5/11, indicated "1. lin today. 2. D/C (discontinue) Cournadin 3 mg p.o. qd. 4. 1 week. (sic)." Indicated 1/17/10 ent was to start 4 mg of a card, indicated it was received on 12/17/10. The medication ablets of Cournadin 4 were still 13 tablets left in the lam tablets had been 1/17/10 though 12/31/10 (15 on should have been 1/11- 1/4/11 (4 tablets should	F3	33			
	This is a total of 19	tablets which should have					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

	CO I OIT MEDIO/IIL	C MICOLOL OF LANDED	~~~~			, OIVID 110.	0000 0031
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		155764	B. Wil	1G_	11	01/14	4/2 <u>01</u> 1
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	us		10	EET ADDRESS, CITY, STATE, ZIP CODE 01 W 87TH AVE IERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRINCENCY)	ULD BE	(X5) COMPLETION DATE
F 333	have been 11 table milligrams in the milligrams in the milligrams in the milligrams. During an interview #7 indicated she had tablets from another half to administer the #7 indicated she had 1/9. LPN #7 indicated sh	to the resident. There should to the resident. There should to left of the Coumadin 4 edication punch card, not 13 on 1/12/11 at 5:15 p.m., LPN to borrowed 6 mg Coumadin or resident and "cut" them in the 3 mg to the resident. LPN and done this twice on 1/7 and ted she did not know why she	F	333			
F 425 SS=D	1/9. LPN #7 indicated she did not know why she did not obtain the medication from the pyxis station. During interview on 1/12/11 at 5:50 p.m., the Healthcare Unit Manager indicated she could not determine what resident the medication had been obtained from. During an interview on 1/12/11 at 7:08 p.m., the ADoN indicated the facility pharmacy had stated the pharmacy had never received the order for the 3 mg Coumadin and needed to have the order faxed to the pharmacy. 3.1-25(b)(9) 3.1-48(c)(2) 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.		F	425	F-425 Pharmaceutical So 1. The Granulex was delivered to the build October 21, 2010.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 65XV11

Facility ID: 010739

If continuation sheet Page 38 of 44



DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 7113 P. 44

PRINTED: 01/21/2011 FORM APPROVED

CENTER	KS FOR MEDICARE	& MEDICAID SERVICES				OMR NO.	<u>0938-0391</u>
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		155764	B. WIN	1G_		01/14	1/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAMP	US			D1 W 87TH AVE		
	OLUMBA BY OTA	TEMENT OF DECOMENDIST		I RVF	IERRILLVILLE, IN 46410	Stean .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 425	Continued From pa	ge 38	F	425	F-425 Continued		
	(including procedur acquiring, receiving	es that assure the accurate			2. All residents have	the	
		drugs and biologicals) to meet			potential to be affected		
	the needs of each r	esident			alleged deficient practi	- '	
	The facility must en	nploy or obtain the services of			3. The licensed staff	will be	•
	a licensed pharmacist who provides consultation				in-serviced on the appro	priate	
	on all aspects of the services in the facil	e provision of pharmacy			way of ordering and obta	ining	
	SELVICES HI IISE IBUII	ity.			drugs.		
					4. The DHS or designe		
					audit the MAR's and drug		
	This REQUIREMEN	NT is not met as evidenced			delivery sheets until 10		
	by:	. d			compliance is achieved t quarterly as part of the		
		view and interview, the facility edications were accurately			facility QA.	•	2/13/11
	received from phan	macy, related to a resident not					
	days, for 1 of 10 res	medication as ordered for 6 sidents reviewed for receiving imple of 10. (Resident #27)					
	Findings include:						
	1/11/11 at 10:37 a.i included, but were failure, hypertensio	record was reviewed on m. Resident #27's diagnoses not limited to, congestive heart n, and benign prostatic ged prostate). Resident #27's date was 10/19/10.			·		
		dated 10/19/10, indicated to ical medication to prevent left heel daily.	•		·		
	10/1/10 through 10/ granulex to left hee	Administration Record), dated /31/10, indicated apply I daily. The following dates, 3 10/24 10/25 and 10/26					

FORM CMS-2567(02-98) Previous Versions Obsolete

Event ID; 8\$XV11

Facility ID: 010739

if continuation sheet Page 39 of 44



PRINTED: 01/21/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING . B. WING 155764 01/14/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN 46410 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ĮD (XS) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 425 Continued From page 39 F 425 were initialed and circled indicating the medication was unavailable. The record lacked documentation as to why the medication was not available. A facility policy, dated 3/1/07, received as current, Executive Director, titled, "Medication Ordering and Receiving from Pharmacy," indicated "Procedures...3. New medications...are ordered as follows:...a. If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. b. Timely delivery of new orders is required so that medication administration is not delayed...B. Receiving Medications from the Pharmacy 1) A licensed nurse:...c. Promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor..." During an interview with LPN #1, on 1/12/11 at 11 a.m., she indicated "I wrote granulex to be delivered on 10/21, because I contacted the pharmacy. I don't know why it wasn't here for those days" 3.1-25(a) F 460 483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL F460 F-460 Bedrooms assure full VISUAL PRÍVÁCY SS≃E visual privacy Privacy curtains in rooms Bedrooms must be designed or equipped to 2216-bed A, 2212-bed A and B, assure full visual privacy for each resident. 2210-bed A and B, 2208-bed A, In facilities initially certified after March 31, 1992. 2205 bed A and B, 2202-bed A, except in private rooms, each bed must have and 1100 bed A and B were ceiling suspended curtains, which extend around replaced the evening of the the bed to provide total visual privacy in

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combination with adjacent walls and curtains.

Event ID:85XV11

Facility ID: 010739

environmental tour.

If continuation sheet Page 40 of 44



No. 7113 P. 46

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED	
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		155764	B. WIN	1G_		01/1	4/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	¥ 1, 0	774011
SPRING	MILL HEALTH CAMP	us			01 W 87TH AVE IERRILLVILLE, IN: 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 460	Continued From pa	ge 40	F4	460	F-460 Continued	· · · · · · ·	
	by: Based on observatifailed to provide privile to gaps in the for 7 of 7 resident road, 2202 bed A, 220. A, 2210 bed A and 2216 bed A) on 2 of Healthcare 2) Findings include: During the environm Maintenance Direct through 3:30 p.m., rand B, 2210-bed A room 2205-bed A a bed A and B, had ain the resident's privile.	or on 01/12/11 at 3 p.m. room 2216-bed A, 2212-bed A and B, room 2208-bed A, and B, 2202-bed A, and 1100- n approximate three foot gap			2. All residents had potential to be affected Grievance/Service Recover Report and Resident Courminutes reviewed with no complaints regarding prisms. All available prismutatins were put up in facility rooms on evening the environmental tour is of any that had a three gap. Additional privacy curtains were ordered. 4. Director of Environmental tour is privacy curtains weekly housekeeping room audit.	ery ncil noted vacy. racy ng of n place foot nmental check with Trends	
i	the Maintenance Di	rector indicated the gaps were e indicated they put the short			Meeting.	at QA	2/13/11
F 514 SS=E	LE	ETE/ACCURATE/ACCESSIB	F 5	514	1. Resident #30, #11, and #88 records were cor		
		intain clinical records on each nee with accepted professional			at the time of survey.		

standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

Jan. 27. 2011 9:00AM Spring Mill Health Campus

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 7113 P. 47 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	ILTIPLE CONSTRUCTION	(X3) DATE S COMPLE	
,445.5446	, contestion		A. BUIL	DING	- I COMPLE	IED
		155764	B. WING	<u> </u>	01/1	4/2011
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	us		STREET ADDRESS, CITY, STATE, ZIP 101 W 87TH AVE MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X6) COMPLETION DATE
F 514 Continued From page 41 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident's clinical records were		F5	2. Current residually will be reviewed for diagnosis and accurrecapitulations and orders. The family will be notified of discrepancies and a corrections made. 3. The licensed	er appropriate cacy of d admission and physician cany appropriate staff will be		
	diagnoses for medi- scale, incorrect fluid and incomplete nar- residents in a samp #30) and 1 of 5 resi- sample of 5 (Reside			in serviced on rece transcribing orders admission orders wi reviewed in the mor meeting 5 days per 4. The DHS or de monitor the recaps admission orders at per week until 100	. New ll be ming clinical week. signee will and new least 5 days	
	1/12/11 at 9:35 a.m included, but were r Disease, peripheral mellitus, and osteoa A physician's order, discontinue accu ch	Resident #30's record was reviewed on 2/11 at 9:35 a.m. Resident #30's diagnoses uded, but were not limited to, Alzheimer's ease, peripheral vascular disease, diabetes litus, and osteoarthritis. hysician's order, dated 10/8/10, indicated to continue accu checks (blood sugar checks). hysician's Recapitulation Order, dated 1/1/11		is achieved. Therea 20 charts per month audited for accurace and the new admits reviewed in the mor 5 days per week.	fter, at least will be y of recaps will be	2/13/11
	through 1/31/11, ind insulin)100 units pe insulin): 150-200=: During an interview	ficated "Humulin R (regular r milliliterSSI (sliding scale 2 units; 2201-250= 4 units" with LPN #1, on 1/12/11 at cated "The order for the				

Jan. 27. 2011 9:01AM Spring Mill Health Campus

ll Health Campus No. 7113 P.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 7113 P. 48 PRINTED: 01/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE S COMPLI	
		155764	B. WING	3	01/1	14/2011
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	us	ļ	STREET ADDRESS, CITY, STATE, ZIF 101 W 87TH AVE MERRILLVILLE, IN 46410	, CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 514	sliding scale should we are not doing at 2. Resident #18's 1/11/11 at 9:30 a.m included, but were shoulder, dementia The physician's ordindicated orders for conditions) for hyperlipidemia, and hyperlipidemia, and hyperlipidemia) for During an interview Healthcare Unit Ma for the above medi 3. Resident #88's 1/12/11 at 9:28 a.m included, but were bleed and congesti The resident's hos 1/10/11, indicated	of not be on the recap because occu checks anymore." record was reviewed on the Resident #18's diagnoses not limited to, fractured right to, and depression. Ider recapitulation, dated 1/11, and depression for depression. Ider recapitulation, dated 1/11, and depression for depression. Ider recapitulation, dated 1/11, and depression for depression. Ider recapitulation, dated the diagnoses cations were not correct. Ider recapitulation for depression was reviewed on the diagnoses and limited to, gastrointestinal to the heart failure. Ider recapitulation, dated depression for diagnoses and limited to, gastrointestinal to the diagnoses and limited to th	F5		·Y)	
	dated 1/10/11, indic	nission physician's orders, cated "Cardizem 180 mg" f documentation of the CD on ardizem.				
	#1 indicated the me	on 1/12/11 at 9:38 a.m., LPN edication name had not been stely on the physician's				
	4. Resident #11's	record was reviewed on				

Jan. 27. 2011 9:01AM Spring Mill Health Campus

DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 7113 P. 49 PRINTED: 01/21/2011 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-03
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SÜRVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		155764	B. WING		01/1	4/2011
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	us	11	BEET ADDRESS, CITY, STATE, ZI 01 W 87TH AVE IERRILLVILLE, IN 46410	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 514	1/12/11 at 9:05 a.m included, but were stage renal disease. A) The resident's p dated 1/11, indicate aspirin for hypertenfor congestive hear hypertension. During an interview DoN indicated the other medications. B) The resident's p dated 1/11, indicate milliliter fluid restriction. The resident's dietawas on a 1000 cc (restriction.	n. Resident #11's diagnoses not limited to, ESRD (end e), hypertension, and arthritis. hysician's order recapitulation, ed the resident was taking usion, Plavix (a blood thinner) at failure, and Zocor for on 1/12/11 at 10:20 a.m., the diagnoses were not correct for hysician's order recapitulation, ed the resident was on a 1200 editor. ary card indicated the resident cubic centimeter) fluid	F 514			

#10739

Indiana !	Indiana State Department of Health			RECEIVED					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIE IDENTIFICATION NUI 155764		A. BUILD B. WING		(X3) DATE SI COMPLE	TED		
NAME OF P	ROVIDER OR SUPPLIER	122104	STREET AD	DRESS CITY	, STATE, ZIP CODE	1 01/1	4/2011		
	MILL HEALTH CAMP	បន			LONG TERM CARE DIVISION NDIANA STATE DEPARTMENT OF HEALTH		ĺ		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF DORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	JULD BE	(X5) COMPLETE DATE		
R 000	R 000 INITIAL COMMENTS		R 000						
	The following State accordance with 41	Residential findings 10 IAC 16.2-5.	are in						
R 036	410 IAC 16.2-5-1.2 Deficiency	(k)(1-2) Residents' R	ights-	R 036	R-036 Resident Rights 1. Residents #81, #46 had their physicians not]		
and a	(k) The facility must immediately consult the resident 'a physician and the resident 'a legal representative when the facility has noticed: (1) a algnificant decline in the resident 'a physical, mental, or psychosocial status; or		s legal ced; s		the time of survey. The been evaluated with no routcomes noted.	ey have negative			
physical, mentel, or psychosocial (2) a need to alter treatment sign a need to discontinue an existing treatment due to adverse consecution commence a new form of treatment		realment eignificently ue an existing form o iverse consequences	, that is, f		2. Current residents will be reviewed for the days. The facility guide will be followed for any	past 30			
Jyan 1	Based on record re falled to notify resid medications not gla sugars, and a skin	net as evidenced by: bylew and interview, ti lents' physician's relate en as ordered, high i condition for 3 of 7 re- lan notification in a s- 164, and #81)	ne facility ted to blood isidents		findings requiring notif 3. The licensed staff in-serviced on the facil guidelines of physician notification. The diabet and the MAR's will be re	will be ity ic books viewed			
	Findings Include:				by the Unit Manager or d at least 5 days a week f	or any			
	01/12/11 at 9:35 a.i included, but were	acoid was reviewed on. The resident's dis not limited to, ohronic ary disease and pros	ignoses :		findings requiring notif 4. The DHS or designe review the MAR's and dia records at least 5 days until 100% compliance is	e will betic per week			
	dated 12/10, indica for CL-7 (herbal su bedtime daily.	sician's recapitulation ted an order, dated 0 pplement), three table	4/16/10, ets at		obtained for 3 weeks, the least 2 days per week as the ongoing QA process. will be reviewed by the	part of Results			
	A Medication Admit dated 11/10, indica	nistration Record (M/ ted the CL-7 was not	(R), given as		QA Committee.		02/21/11		
1/\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		DER/SUPPLIER REPRESEN		NATURE E	xeative Director	2	(X6) DATE		

STATE FORM

85XV11

If continuation sheet 1 of 22

Indiana	State Department of	Health			<u> </u>			
	T OF DEFICIENCIES OF GORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI A, BUILDING B, WING	PLE CONSTRUCTION G	(X3) DATE S COMPU		
NAME OF F	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		~/##11	
	MILL HEALTH CAMP	ะบร	101 W 87	•				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETE DATE	
R 036	ordered on 11/08/1 medication was un A MAR, dated 12/1 given as ordered by 12/02/10, 12/04/10 ordered by the phy was unavailable. There was a lack o physician was awa and was unavailab 12/13/10. During an interview the Residential Uni physician had not a getting the medical indicated the physi earlier than 12/13/1 2. Resident #46's 01/11/11 at 1:45 p. included, but were and Alzheimer's Di The physician's rec 01/11, indicated ar accu-checks (blood completed daily at indicated the resid notified for blood s The MAR, dated 11 blood sugar on 12/10 units of insulin v There was a lack of	O through 11/30/10 of available. O, indicated the CL-7 y the physician on 12, 12/11/10, and 12/12 sician due to the ment of documentation the rathe CL-7 had not y le from 11/01/10 throw on 01/12/11 at 10:1 it Manager Indicated been notified of the retion until 12/13/10. Scian should have been notified of the retion until 12/13/10. Scian should have been not limited to, diabet is ease. capitulation orders, diabet is ease. capitulation orders, diabet is ease. capitulation orders, diabet is ugar monitoring) to 6 a.m. and 4 p.m Then's physician was trugars over 400. 2/10, indicated the received of documentation on the following of the follow	was not 201/10, as dication resident's cean given ough 0 a.m., the annotified on agnoses es mellitus ated 9/10 for the order to be sident's 424, and the 12/10	R 036				
	MAR and in the res	sident's record to ind n had been notified o	icate the					

Indiana State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155764 01/14/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN 48410 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY PULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) R 036 Continued From page 2 R 036 blood sugar over 400. During an interview on 01/12/11 at 9:10 a.m., the Residential Unit Manager indicated the resident's physician had not been notified of the blood sugar over 400 on 12/25/10. Resident #64's record was reviewed on 01/12/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to. Atcheimer's Disease and osteoarthritis. A physician's order, dated 12/15/10, indicated the resident had an abscessed lesion on the top of her right foot. The order indicated to apply Silvadene Cream (topical antibiotic) and a dressing daily for 10 days and then notify the physician of the healing progress. The resident's nurses' notes lacked documentation to indicate the resident's physician R-144 Sanitation and Safety had been notified as ordered, of the status of the Standards area after the 10 days of treatment. Room 110 and 114 had During an interview on 01/12/11 at 10:50 a.m., heaters repainted at the time of the Residential Unit Manager indicated the the survey. The table veneer physician had not been notified as ordered. will be replaced. All chairs in the dining room will be R 144 410 IAC 16.2-5-1.5(a) Sanitation and Safety R 144 repaired. The hole in the back Standards - Deficiency of the cabinet was patched at (a) The facility shall be clean, orderly, and in a the time of the survey. Juice state of good repair, both inside and out, and streaks on the front of the shall provide reasonable comfort for all revidents. cabinets in the main dining room This RULE is not met as evidenced by: were cleaned at the time of Based on observation and interview, the facility survey. The liquid butter on the failed to ensure the facility was clean and in good pub lounge cabinet and dirt on repair related to chipped paint on heaters, the shelves were cleaned. scratched chairs and missing veneer on a table, a Indiana State Department of Registr

Indiana :	State Department of	Health					
	T OF DEFICIENCIES OF CORRECTION	(X1) PRÓVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULT A. BUILDIN B. WING		(X3) DATE SI COMPLE	TED
		155764				01/14	W2011
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
SPRING	MILL HEALTH CAMP	US	101 W 87 MERRILL	TH AVE VILLE, IN 4	6410	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XE) COMPLETE DATE
R 144	Continued From pa	ge 3		R 144	R 144 Continued		
	hole in a cahinet w	hich had the notentia	l to affect		2. All residents have	the	
		le in a cabinet, which had the potential to a of 10 residents who reside on the Memon are Unit, and juice stains on the outside of			potential to be effected	by the	
	Care Unit, and juice			•	alleged deficient praction	ce. All	
	cebinet in the main dining room and and a di				rooms were inspected and	heaters	
	cabinet in the pub lounge, which had the pote to affect 47 of 47 residents who live in the Residential Unit.				upgraded as needed. All	cabinets	
			,-		have been checked for nee	eded	
					repairs. All cabinets hav	ze been	
	Findings include:	•			cleaned. There were no ne	egative	
	During the environs	nental tour on 01/12/	11 at 2:25		outcomes noted during the	e time .	
	p.m. through 3 p.m	, with the Maintenand			of these inspections.		
	Director, the follow	ng was observed:			3. The Director of Pla	ant	
	1. Memory Care Ur	rit:			Operations (DPO) will be	in-	•
	it morney bars of	1141	ĺ		serviced on checking heat	ers,	
,		had numerous paint			tables, chairs & cabinets	3	
		ters in the resident's rat the time of the ob			routinely. Environmental		
		raction indicated he c			services staff will be in	1-	
1	resident's rooms w		.,		serviced on routine clear	ning of	
	- 66	11 % 1	, .,		cabinets and shelves.		
	veneer off of the sid	n the dining room ha	orme ∣		4. The DPO or designee	e will	
I	ACTION OF THE SIL	as or dic table.			check heaters, chairs & t	ables 2	
		re dining room were			x's per week as part of		
		ig an interview at the			preventative maintenance	rounds.	
		 Maintenance Direct get scraped from th 			Director of Environmental		
	Transcaum and Gright	a Antonichon Halli at	4 (40,0)		Services (DES) will monit	or	
		n the back of the cabi	inet in the		cleanliness of shelves ar	ıd	
	resident lounge				cabinets daily until 100%	·	
	2. There were luice	streaks on the front	ofthe		achieved. After compliand		
	cabinets in the mai				achieved DPO & DES will π	onitor	
	m &t: -: -: -:	=			all areas weekly. Trends	will be	
[pub lounge had spille le shelves. During an			reported at the monthly (Α̈́	
		pservation, the Maint			meeting.		02/21/11
		lousekeening or the]		

India is	State Debotatient of	(REGILL!					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN	IPLE CONSTRUCTION	(XS) DATE SI COMPLE	
		155784		B. WING		01/1/	4/2011
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SPRING	MILL HEALTH CAMP	นร	101 W 87 MERRILLY	TH AVE VILLE, IN 4	5410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XS) COMPLETE DATE
R 144	Continued From pa	ge 4		R 144			
	•	_		• • •			
	debautueur were ei	uppose to clean the s	irea.				
R 148	 410 AC 18 2-8-1 6	(e)(1-4) Sanitation ar	nd Sofatio	R 148	R-148 Sanitation and Saf	etv	
14 170	Standards - Deficie		in contry	11 140	Standards		
		-			1. The lint in the be	autv	
		í maintain buildings, í			shop was cleaned at the	_	ļ '
		i clean condition, in g nazards that may adv			the survey.	1	[
		d welfare of the resid			2. All residents who	visit	
-	the public as follow	B :			the beauty shop have the		
		all establish and imple			potential to be effected		
	continued upkeep o	maintenance to ensi of the facility	nie nie		alleged deficient practi		Ì
		ystem, including appl	iances.		There were no negative o		
		ernate power source			noted.		
		n systems, shall be m unctioning and comp			3. Environmental serv	ices	
	with state electrical				staff and beauticians wi	ll be	
	(3) All plumbing sha	all function properly a	ınd		in-serviced on the proce	ss of	1
	comply with state p		_		cleaning the hair dryers		ļ
	(4) At least yeany, I systems shall be in	heating and ventilatin spected	193		routinely.		
		,			4. The DES or designe	e will	}
		net as evidenced by:			check the Beauty Shop we		
İ		ion and interview, the building was free of			proper cleaning of the h	_	
II.		rulation of lint build u			dryers. Trends will be r		
ı	hair dryers in 1 of 1	Beauty Shop, This I	has the		monthly at the QA meetin		02/21/11
	potential to affect 5 the residential facili	7 of 57 residents who ity.	ive in				02/21/11
	Findings include:					ļ	
	p.m. through 3 p.m Director, the Beaut	mental tour on 01/12/ , with the Maintenand y Shop was closed. T lint in two of two hair	e here was				
	During an interview	at the time of the ob	servation,				

Indiana :	State Department of	Health					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIE IDENTIFICATION NUM		(X2) MULT A. BUILÓIN B. WING		(X3) DATE S COMPLE	TED
WANE OF B		199194	OTRECT NO	DDEGR ATTY	OTATE SINGAP	01/1	4/2011
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	ບຣ	101 W 87		STATE, 2IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCY TO THE APPR DEPICIENCY)	JLTI BE	(X5) COMPLETE DATE
R 148	Continued From pa	ge 5		R 148			
	the Maintenance Director indicated the Beauticia cleans the Beauty Shop.						
R 154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubblish, and maintained in good repair in accordance with 410 IAC 7-24. This RULE is not met as evidenced by: Based on observation and interview, the facility falled to keep kitchen areas clean related to dirty refrigerators/freezers for 2 of 3 refrigerators in resident lounges (Memory Care Unit and the Pub Lounge). This had the potential to affect 10 of 10 residents who reside in the Memory Care Unit and 47 of 47 residents who reside in the residential facility.		ifety	R 154	R-154 Sanitation and Sa Standards	fety	
			t, and h, and		1. The freezer and the in the Memory Care Unit cleaned at the time of the survey. The Pub freezer refrigerator were cleaned	was he and	
			d to dirty tore in I the Pub 10 of 10 Unit		time of the survey. 2. All residents have potential to be effected alleged deficient practic There were no negative or noted. 3. The environmental staff will be in-serviced.	the by the ce. utcomes	
	Findings Include:				cleanliness procedures reto freezers and refriger	elated	
		nental tour on 01/12/ with the Maintenanc ng was observed:		-	4. The DES or designed conduct daily rounds of a and refrigerators until	e will freezer	
	aticky substance sp Memory Care Unit. door was dirty and i on the seal. During observation, the Ma	ied brown substance illied in the freezer in The seal around the ned a brown crusty so an interview at the freezer in the area to clean the freezer to clean	the freezer ubstance me of the idicated		compliance is achieved. A compliance is achieved DI conduct weekly rounds. To will be reported at the rQA meeting.	After ES will cends	02/21/11
	freezer of the Pub L pink substance spill	cumulation of ice in to ounge freezer. Ther ed in the refrigerator, ime of the observation	e was a During				

11VX38

Indiana :	State Department of	Health					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULT A. BUILDIN B. WING		(X3) DATE SU COMPLE	
NAME OF P	PROVIDER OR SUPPLIER	1001.04	STREET AD	DRESS, CITY,	STATE, ZIF CODE	W 1 / 1	WZUTI
	MILL HEALTH CAMP	US	101 W 87				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIE: Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XS) COMPLETE DATE
R 154	Continued From pa	ige 6		R 154		(
	Maintenance Direct housekeeping or ac the area.	tor indicated either ctivities were suppose	e to clean				
R 241	(e) The administration provision of resident ordered by the resident ordered by the resident or on call as follows (1) Medication shall nursing personnel of this RULE is not in Based on record refailed to ensure phyrelated to medication medications not give supplements not distreatments not comphysician was not or residents reviewed	ci)(1) Health Services in of medications are tall nursing care shadent 's physician and ensed nurse on the passed nurse on the passed nurse on the passed nurse on the passed nurse on edication at as evidenced by: eview and interview, the passed nurse orders were one not held as ordered as ordered, dietar scontinued as ordered and totified as ordered for following physicial of 7. (Residents #46,	nd the as d shall be as d shall be as dicensed on aides. the facility of followed, red, ry ed, and the ar 4 of 7 ans'	R 241	R-241 Health Services 1. Residents #68, #64 and #81 were evaluated at time of survey and no new outcomes were noted. Physwere notified per guidel: 2. All residents have potential to be effected alleged deficient practic Current residents' MAR's reviewed for the last 30 Orders will be followed accordingly and physician notified per guidelines. 3. All licensed staff in-serviced on following physician orders and physiciation.	t the gative sicians ines. the by the ce. will be days.	
	1. Resident #68's n 01/12/11 at 11:35 a included, but were n stroke. The resident's recal dated 12/10, indical dated 02/15/10, for lab, one tablet daily		liagnoses tia and orders, an order, a chew		4. The Unit Manager of designee will review the at least 5 times weekly the 100% compliance is obtain 3 weeks, then 2 times per as part of the ongoing QA process.	e MAR's until ned for week	02/21/11
		and Physical", dated					

(ndiana	State Department of	Health		·			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 155764		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) CATE S COMPLE 01/1	
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	STREET AD	DRESS, CITY, 8	STATE, ZIP CODE		-
•	MILL HEALTH CAMP	U\$	101 W 87	1	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIPYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETE DATE
R 241	(times) 2 this morni (test for blood) from Department)Staff that the emesis approught here by far 23 hour observation A hospital, "Discha 12/24/10, indicated blood with possible. The hospital return indicated, "noas (physician's name). There was a lack oresident's record to the hospital, return resident's physician to hold the aspirin. The Medication Addated 12/10, indicated 12/10, ind	to coffee-ground eming, also hemoccult-in the ED (Emergency of at the assisted living beared coffee-ground milyShe was admittin" The Summary dated a diagnoses of positing gastrointestinal blee orders, dated 12/24/spirinuntil okay with indicate the resident and from the hospital, in had been notified of ministration Record (fed the resident recept of the position of the resident recept of the resident recept of the resident recept of the resident recept of the resident recept of the resident recept of the resident recept of the resident recept of the resident recept of the resident recept of the resident recept of the resident recept of the resident recept of the resident recept of the resident recept of the resident recept of the resident to the	oositive / noted if and was ed under if ed under it ed. /10, if ed the and the f the order (MAR), ived the 10. sident irough .m., of seen ed he ne	R 241	DEPICIENCY		
	the Residential Uni not recall the reside	on 01/11/11 at 11:19 t Manager indicated a ent going to the hosp n was not held as ore	she did Ital. She				

Indiana State Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 155764 01/14/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 101 W 87TH AVE SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN 48410 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY R 241 R 241 Continued From page 8 the physician. She indicated the physician had not been notified of the order to hold the aspirin. Resident #64's record was reviewed on 01/12/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and osteoarthritis. A physician's order, dated 12/15/10, indicated the resident had an abscessed lesion on the top of her right foot. The order indicated to apply Silvadene Cream (topical antibiotic) and a dressing daily for 10 days and then notify the physician of the healing progress. The MAR, dated 12/10, indicated the treatment to the abscess was not completed daily for the 10 days. The resident's nurses' notes lacked documentation to indicate the resident's physician had been notified as ordered, of the status of the area after the 10 days of treatment. During an interview on 01/12/11 at 10:60 a.m., the Residential Unit Manager indicated the treatment was not completed daily as ordered. She indicated the physician had not been notified as ordered. 3. Resident #48's record was reviewed on 01/11/11 at 1:45 p.m. The resident's disgnoses included, but were not limited to, diabetee mellitus and Alzheimer's Disease. A) A physician's order, dated 10/19/10 indicated an order to discontinue the resident's 60 cc's (cubic centimeters) med pass (dietary supplement) three times a day.

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Indiana l	State Department of	<u>Health</u>						
	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 158764			(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SI COMPLE	TED	
NAME OF P	ROVIDER OR SUPPLIER	L	ETREET ADI	ET ADDRESS, CITY, STATE, ZIF CODE				
	MILL HEALTH CAMP	υs	101 W 87		•		'	
(X4) ID PREFIK TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
R 241	received 2-cal HN (therapeutic exchan three times a day fr 11/30/10. The MAR, dated 12 received 2-cal HN, 12/01/10 through 1: The MAR, dated 01 received 2-cal HN, 01/01/11 through 0 During an interview Residential Unit Ma was used for the M not discontinued as still receiving the 2- B) The physician's 01/11, indicated an accu-checks (blood completed daily at indicated the reside Humulin regular ins per result of the blo < (less than) 151= (151-200= 2 units of 201-250= 4 units 301-350= 8 units 301-350= 8 units 351-400= 10 units > (over) 400= call the	idietary supplement of dietary supplement of	seed as a locc's locc's leident day from sident day from n., the 2-cal HN ted it was day. day. day. day. day. sident sident was local for local fo	R 241	DEFICIENCY)			
		t/10, indicated the re: 25/10 at 4 p.m. was 4 vas given.			,		The state of the s	
	There was a lack of	f documentation on t	he 12/10					

Indiana	State Department of	Health					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM 185764	R/CLIA MBER:	(X2) MULT A. BUILDIN B. WING		(X3) DATE S COMPL	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY.	STATE, ZIP CODE		
	MILL HEALTH CAMP	us	101 W 87				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	n should be Eappropriate	(X5) COMPLETE DATE
R 241	Continued From pa	ige 10		R 241			
	MAR and in the res	- ident's record to Indi had been notified o			,		
		f documentation to in red 10 units of insulin augar of 424,					
	blood sugar on 01/0	i/11, indicated the re 06/11 at 4 p.m. was 2 gular insulin was give	67 and 4				
	Residential Unit Me	on 01/11/11 at 1:50 unager indicated the r ed alx units of insulin	esident				
	Residential Unit Mu physician had not b sugar over 400 on 1	on 01/12/11 at 9:10 an ager indicated the sen notified for the b 12/25/10. She indica units of insulin for a	resident's lood ted the				
	01/12/11 at 9:35 a.r included, but were r	ecord was reviewed n. The resident's dia not limited to, chronic ary disease and pros	gnoses				
	dated 12/10, Indicat	lcian's recapitulation ted an order, dated 0 oplement), three table	4/18/10,				
•		ed 10/30/10 at 4:20 p nt's family was notifie needing refilled					
	A MAR, dated 11/10), indicated the CL-7	was not	`			

No. 7444 P. 21) PRINTED: 02/07/2011 FORM APPROVED

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROMDER/SUPPLIE IDENTIFICATION NUM	R/CLIA VBER:	(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		156764	-	THEOR OFFICE	STATE, ZIP CODE	U7/14	/2011
,	rovider or supplier MILL HEALTH CAMP	ŭŝ	101 W 871				
(X4) ID PREPX TAG	(EACH DEFICIENCY	TEMENT OF DEPICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION 8HO) GROSS-REFERENCED TO THE APPR DEFICIENCY)	VLOBE.	(X6) COMPLETÉ DATÉ
R 241	Continued From pa given as ordered or as ordered by the p	ge 11 n 11/08/10 through 1 rhysician due to the n	1/30/10 nedication	R 241			
	was unavailable. A MAR, dated 12/1 given as ordered by 12/02/10, 12/04/10 to the medication w. There was a lack or physician was aware.	0, indicated the CL-7 y the physician on 12 , 12/11/10, and 12/12	was not /01/10, //10, due resident's seen given		·	·	
	During an interview the Residential Unifamily does not brit should order the management of the medical physician had not the medical petting the medical	on 01/12/11 at 10:10 t Manager indicated in medications, the edications from the blicated the resident hation as ordered and been notified of the retion until 12/13/10. Scien should have been 10.	if the e staff eack up each not the esident not he				
₹ 273	Services - Deficien (f) All food prepara (excluding areas in maintained in acco	tion and serving area residents ' units) an rdance with state and food handling stand	is e dilocal	R 273	R-273 Food and Nutritic Services 1. The Ice Cream Parl refrigerator and Memory Unit refrigerator had all opened, undated and unla food thrown out the day	.or Care .l .beled	
	Based on observat failed to follow safe related to undated, stored refrigerators	met as evidenced by: ion and Interview, the food handling stand outdated, and unlab in 2 of 3 resident lou I Memory Care Unit I	e facility arda eled food Inges (Ice		survey tour.	. = 2.00	

Indiana :	State Department of	Hesith					
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE (DENTIFICATION NUI	R/CLIA VIBER;	(X2) MULT A. BUILDIN B. WING _		(X3) DATE 81 COMPLE	TOD
		155764	ATREPT AN	DECO OVO	OTATE Manage	01/14	1/2011
	ROVIDER OR SUPPLIER MILL HEALTH CAMP	US	101 W 87		STATE, ZIP CODE 6410		ļ
(X4) ID PREFIX TAG	(EACH DEPICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY BC IDENTIFYING INFORMA	FULL :	(D PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT OROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETE DATE
R 273	Continued From pa	de 12		R 273	R 273 Continued		
	-		enaldonia		2. All residents have	the	
		ital to affect 10 of 10 lemony Care Unit and			potential to be effected	by the	
		le in the residential fa			alleged deficient practi		
			-		There were no negative o		
	Findings include:				noted.	İ	
	During the environ	nental tour on 01/12/	11 at 2:25		3. Director of Dining		
	p,m. through 3 p.m.	. with the Maintenand			Services will be in-serv	iced on	
	Director, the following	ng was observed:			proper labeling and datis	ng	
	1. The following wa	s stored in the ice C	ream		procedures.		1
ı	Lounge refrigerator		*****		4. The DES or designe	e will	
			244		monitor freezer and		
		peled and undated of ", with an expiration o			refrigerators in the Ice	Cream	
	11/15/10.	1 mar our ardenman			Parlor and Memory Care U	nit 5	
					days per week. Trends wi	ll be	
	There was an unda	ited, unlabeled, and substance in a jar. [lucina sa		reported at the monthly	AÇ	
	interview at the time	e of the observation, tor indicated maybe t	the		meeting.		02/21/11
		ied, undated and unk elphia cream cheese 1/10.				l	
	red substance with and undated. Durir	container of an unid rice, which was unlang an interview at the Maintenance Direct like Spanish Rice.	beled time of				
	There was a covere which was unlabele	ed plastic bowl of letted and undated.	uce,				:
· · ·	2. The following wa Unit lounge refriger	s stored in the Memo ator:	ory Care				,
	An unlabeled, unda	ited box of chicken w	ings.				

Indiana :	State Department of	Health					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIE IDENTIFICATION NUM 155764	R/CLIA MBER:	(X2) MULT A. BUILDIA B. WING		(X3) DATE SI COMPLE 01/14	JRVEY TED 4/2011
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SPRING	MILL HEALTH CAMP	ບຣ໌	101 W 87 MERRILL	TH AVE VILLE, IN 4	6410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST SE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(28) COMPLETE DATE
R 273	During an Interview Residential CNA #3 She Indicated she oupstairs. An opened and look yogurf, which was a During an interview	r at the time of the ob indicated it was her lidn't have time to tal sely covered contain indated and unlabele or at the time of the	supper. ke it er of ed.	R 273			
	observation, the Maintenance Director indicated looked like someone had taken a spoonful out of the container. There was an undated and unlabeled thawed carton of Mighty Shake.				R-297 Pharmaceutical Se	cvices	
R 297	410 IAC 16.2-5-6(c Noncompliance)(1) Pharmaceutical	Services - l	R 297	1. Resident #81 had pl	ot being	: !
	shall do the following (1) Make arrangement pharmaceutical servised and the contract of the co	itions for a resident, i ig for that resident	provide		given. There were no negativen. There were no negative outcomes noted. 2. The current resider MAR's will be reviewed for last 30 days. Proper followed and notification will occurred.	nts or the low up	
	Based on record re failed to ensure a re prescribed medicat physician for 1 of 7	net as evidenced by: view and interview, the esident was provided ions as ordered by the resident's reviewed to vices in a sample of	he facility I with ne for		3. The licensed staff in-serviced on the proper procedures when medication not readily available. 4. The Unit Manager or designee will monitor the	on is	
	Findings include:	ord was reviewed on	01/12/11		at least 5 days per week 100% compliance is achieved than twice per week for 3	ed and	
	at 9:35 a.m. The re but were not limited	esident's diagnoses li to, chronic obstructly and prostate cancer.	ncluded, Ve		then twice per week for 3 months. Trends will be reat the QA meeting.		02/21/11
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85XV11

Indiana State Department of Health

No. 74447 P. 24; PKINTED: 02:07/2011 P. FORM APPROVED

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDIN		(X3) DATÉ BURVEY COMPLETED	
		155764	•	B. W(NG_		01/14/2011	
NAME OF P	NOVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIF CODE		
SPRING	MILL HEALTH CAMP	US	101 W 87T MERRILLY	H AVE /ILLE, IN 4	8410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	id Prefix Tag	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
R 297	Continued From pa	ge 14		R 297			
	The resident's physician's recapitulation orders, dated 12/10, indicated an order, dated 04/18/10, for CL-7 (herbal supplement), three tablets at bedtime daily.						
	A nurses' note, dated 10/30/10 at 4:20 p.m., indicated the resident's family was notified the resident's CL-7 was needing refilled.						
	A Medication Administration Record (MAR), dated 11/10, indicated the CL-7 was not given as ordered on 11/08/10 through 11/30/10 as ordered by the physician due to the medication was unavailable.						
	given as ordered by	0, indicated the CL-7 y the physician on 12 , 12/11/10, and 12/12 yas unavaliable.	/01/10,				
	the Residential Unit family does not brin	on 01/12/11 at 10:1 t Manager indicated ig in medications, the edications from the b	if the				
R 298	410 IAC 16.2-5-6(c Deficiency)(2) Pharmaceutical	Services -	R 298	R-298 Pharmaceutical Ser 1. Expired medication	was .	
	under contract, and				discarded and refrigerat medication rooms were cl with food discarded at t	eaned	
	850 IAC 1-7;	for the duties as spe- handling and storag			of the survey.	THE CIME	
	practices in the faci	ility;				1	
		etion on methods an					
ļ		ring, storing, adminis ugs as well as medic					

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	STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:		R/CLIA MBER:	(X2) MULT A. BUILDIN B. WING_	TPLE CONSTRUCTION	(X3) DATE SI COMPLE	部的
NAME OF P	ROVIDER OR SUPPLIER	300744	STREET AD	DRESS CITY	STATE, ZIP CODE	<u>U1/1</u> -	4/2011
	MILL HEALTH CAMP	ມຣ	101 W 87			•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY BC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT GROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
R 298	Continued From pa	ge 15		R 298	R 298 Continued	***************************************	
	(D) report, in writing her designee any in administration of dr. (E) review the drug receiving these service) days. This RULE is not in Based on observations.	egularities in dispenugs; and regimen of each resided at least once extent as evidenced by; on, record review, an	sing or Ident Yery sixty		2. The licensed staff be in-serviced on the appropriate procedures f handling expired medicat and keeping medication refrigerators clean and food.	or ions oom without	
	interview, the facility were not expired for receiving their medi pass observations (ensure medication strollowed related to 3 (1st floor, 2nd floor, dirty and employee medication refrigers potential to affect 58 their medication from	1 of 5 resident's obsections during two maresident #81) and falstorage practices well of 3 medication refrand Memory Care U food stored in 1 of 3 stores (1st floor). This 5 of 57 residents who	served ledication led to re ligerators init) were		3. The unit manager of designee will conduct date audits for 3 weeks or un 100% compliance is obtain Audits will then be conduced with trends report monthly QA meetings.	ily til ned. ucted	02/21/11
	Findings include: 1. During a medicate 01/11/11 at 10:25 a prepared resident # included Procosa II Residential LPN #1 Procosa II from the of Procosa II indicate 09/10. During an interview Residential LPN #1 when the Procosa II resident from the far are suppose to check give the medications.	m., Residential LPN 81's medication, white (glucosamine supple removed the two both medication cart. Both edication edite medication edite the medication edite the time of the obsindicated he was unsupplied to the indicated the expiration dates with the control of the expiration dates with the indicated the expiration dates with the indicated the expiration dates with the indicated the expiration dates with the indicated the expiration dates with the indicated the expiration dates with the indicated the expiration dates with the indicated the expiration dates with the indicated the expiration dates with the indicated the expiration dates with the indicated the expiration dates with the indicated the expiration dates with the expiration	#1 ch ch chement). tles of th bottles xpired on servation, sure te nurses hen they				

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PRINTED: 02/07/2011 FORM APPROVED Indiana State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND FLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A, BUILDING B. WING 155764 01/14/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN 46410 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X6) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY R 298 R 298 Continued From page 16 at 9:35 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and prostate cancer. The physician's recapitulation orders, dated 12/10, indicated the glucosomine had been ordered on 08/14/10. The order indicated the resident was to receive two capsules of the glucosamine once a day, 2. During the environmental tour on 01/12/11 at 2:25 p.m. through 3 p.m. with the Maintenance Director, the following was observed in the First floor medication room: There was a brown spilled liquid on the door and bottom of the refrigerator. There was a plastic bag filled with grapes, a plastic bag filled with chips, a fruit cooler, a "Go Gert", and a bottle of water, which were all undated/unlabeled, and stored in the refrigerator. During an interview at the time of the observation, Residential LPN #1 Indicated the night shift was suppose to clean the medication room. He indicated he did not know who the food belonged to. The Maintenance Director indicated it was not a resident's food. During an observation of the medication. refrigerator in the Memory Care Unit, on 01/12/10 at 9:20 e.m., with Residential LPN #2, there was a brown substance spilled on the top shelf of the medication refrigerator and the seal of the door

Indiana State Department of Health

refrigerator was dirty.

had a large amount of black mold on it. During an

Interview at the time of the observation. Residential LPN #2 acknowledged the

FORM APPROVED Indiana State Department of Health STATEMENT OF DEFICIENCIES (X3) DATE BURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 155764 01/14/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 101 W 87TH AVE SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN 46410 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 304 R 304 Continued From page 17 R-304 Pharmaceutical Services R 304 R 304 410 IAC 16.2-5-6(e) Pharmaceutical Services -The door was closed and Deficiency the fan was moved during the (e) Medicine or treatment cabinets or rooms shall time of the survey. be appropriately locked at all times except when All residents have the authorized personnel are present. All Schedule II potential to be effected by the drugs administered by the facility shall be kept in alleged deficient practice. individual containers under double lock and stored in a substantially constructed box, cabinet, There were no negative outcomes or mobile drug storage unit. noted during this occurrence. Licensed staff will be This RULE is not met as evidenced by: in-serviced on securing the Based on observation and interview, the facility failed to ensure a medication room and/or Memory Care nurses' office by refrigerator was locked at all times, related to the consistently keeping the door Memory Care Unit nurses' station door being left locked. open. There was an unlocked medication refrigerator located in the nurses' station. This 4. The Unit Manager or had the potential to affect 10 of 10 residents who designee will conduct rounds live on the unit, with the diagnoses of Alzheimer's twice daily to ensure that the Disease and/or dementia. door is locked for 1 week or Findings Include: until 100% compliance is achieved. Door will be observed During an observation on 01/12/11 at 8:45 a.m. locked during daily rounds as through 9:20 a.m., the door to the nursea' station in the Memory Care Unit was left open, and a part of ongoing QA process. 02/21/11 floor fan was running and sitting in the doorway. The staff member on the unit was down the hall. in the dining room with some of the residents from the unit. During an observation on 01/12/11 at 9 a.m. to 9:18 a.m., there were two residents who walked up to the open door, attempted to walk into the nurses' station around the fan, then lurned and walked down the hallway.

During an observation of the unlocked refrigerator located in the nurses' station on 01/12/11 at 9:20

Indiana State Department of Health								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
		155764	STODET AN	Nakod vuv	STATE 210 CACE	01/1/	4/2011	
101 W 87T			DRESS, CITY, STATE, ZIP COOE TH AVE VILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDEN'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMPLETE		
R 304	Continued From page 18 a.m. with Residential LPN #2, there were three vials of insulin and a plastic container with a plastic lock on it, which contained medications. During an interview on 01/12/11 at 9:20 a.m., Residential LPN #2 indicated the door had been left open because of water on the carpeting. She indicated the residents on the unit could get into the nurses' station and could get into the refrigerator. She indicated the door was normally closed.			R 304				
R 349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents' records were complete and accurate related to medication administration and changes in conditions for 3 of 7 resident's records reviewed in a sample of 7. (residents #46, #64, and #68) Findings include: 1. Resident #68's record was reviewed on 01/12/11 at 11:35 a.m., The resident's diagnoses included, but were not limited to, dementia and stroke.			R-349 Clinical Records 1. Residents #68, #64, and #46 were evaluated at the time of survey with no negative outcomes noted. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The licensed staff will be in-serviced on appropriate documentation related to medication administration and changes in condition. 4. The Unit Manager or designee will review 24 hour report book and MAR's 5 times per week until 100% compliance is obtained. Once compliance is obtained reviews will be done 2 times per week. Trends will be prought to monthly QA meeting.		02/21/11		
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SYATEMENT OF DISFORMAND STATEMENT OF DISFORMAND NUMBER: NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS SUMMARY STATEMENT OF DISFORMAND STAT	Indians State Department of Health								
SPRING MILL HEALTH CAMPUS SPRING MILL HEALTH CAMPUS A LAW STH AVE SECULATORY OF DESCRIPTION (EACH DESCRIPTION MILE IN 48419 PROPERLY RESULATORY OR LSO IDENTIFYING INFORMATION) R 349 Continued From page 19 A hospital, "History and Physical", dated 12/23/10, indicated, " sent here from the assisted living due to coffee ground emesis x (times) 2 this morning, also hemocoult-positive (test for blood) from the ED (Emergency Department). Staff at the assisted living noted that the emesis appeared coffee ground and was brought here by family. She was admitted under 23 hour observation" The hospital return orders, dated 12/24/10, indicated, " o aspirin until okay with (physician's name)" There was a lack of documentation in the resident's record to indicate the resident's status after returning from the hospital, returned from the hospital, and the resident's status after returning from the hospital, returned from the floating and the resident's record documentation in the resident's record to indicate the resident's record about the resident's record was reviewed on 01/12/11 at 10:25 a.m. The resident's record was reviewed on 01/12/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, Atzheimer's Disease and osteoarthritia, A physician's order, dated 12/15/10, indicated the resident had an ebecasesal lesion on the top of	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER		R/CLIA MBER:	A. BUILDING		COMPLETED			
MERRILLVILLE, IN 48410 (CA) ID SUMMARY STATEMENT OF DEFICIENCIES PREFER TAG R 349 Continued From page 19 A hospital, "History and Physical", dated 12/23/10, indicated, "sent here from the assisted living due to coffee-ground emesis x (times) 2 this morning, also hemocoult-positive (test for blood) from the ED (Emergency Department). Saff at the assisted injug noted that the emesis appeared coffee-ground and was brought here by familyShe was admitted under 23 hour observation" The hospital return orders, dated 12/24/10, indicated, "noaspirinuntil okay with (physician's name) There was a lack of documentation in the resident's record to indicate the resident's status after returning from the hospital, returned from the hospital, and the resident's status after returning from the hospital, the Residential Unit Manager indicated there was no documentation in the resident's record about the resident's condition. 2. Resident's condition. 2. Resident #64's record was reviewed on 01/12/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, Atzheimer's Disease and osteoarthritis. A physician's order, dated 12/15/10, indicated the resident had an abbooseseal tesion on the top of	NAME OF P	ROVIDER OR SUPPLIER		STREET AD					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) R 349 Continued From page 19 A hospital, "History and Physical", dated 12/23/10, indicated, "sent here from the assisted living due to coffee-ground emesis x (times) 2 this morning, also hemoccult-positive (test for blood) from the ED (Emergency Department)Staff at the assisted living noted that the emesis appeared coffee-ground and was brought here by familyShe was admitted under 23 hour observation" The hospital return orders, dated 12/24/10, indicated, "noaspirinuntil okay with (physician's name)" There was a lack of documentation in the resident's record to indicate the resident had a coffee-ground emesis, went to the hospital, returned from the hospital, returned from the hospital, and the resident's status after returning from the hospital. During an interview on 01/11/11 at 11:10 a.m., the Residential Unit Manager indicated there was no documentation in the resident's record about the resident's condition. 2. Resident #64's record was reviewed on 01/12/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, Atzheimer's Disease and osteoarthyitla, A physician's order, dated 12/15/10, indicated the resident had an abscassed lesion on the top of	101 W 87T				6410				
A hospital, "History and Physical", dated 12/23/10, indicated, "sent here from the assisted living due to coffee-ground emesis x (times) 2 this morning, also hemocoult-positive (test for blood) from the ED (Emergency Department)Staff at the assisted living noted that the emesis appeared coffee-ground and was brought here by familyShe was admitted under 23 hour observation" The hospital return orders, dated 12/24/10, indicated, "noaspirinuntil okay with (physician's name)" There was a lack of documentation in the resident's record to indicate the resident had a coffee-ground emesis, went to the hospital, returned from the hospital, and the resident's status after returning from the hospital, buring an interview on 01/11/11 at 11:10 a.m., the Residential Unit Manager indicated there was no documentation in the resident's record about the resident's condition. 2. Resident #64's record was reviewed on 01/12/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, Atzheimer's Disease and osteoarthitla, A physician's order, dated 12/15/10, indicated the resident had an obsessed lesion on the top of	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(PACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE COMPLETE EAPPROPRIATE DATE		
her right foot. The order indicated to apply Silvadens Cream (topical antibiotic) and a dressing daily for 10 days and then notify the physician of the healing progress. A, "Skin Circumstance" form indicated the resident's right foot was assessed each shift for 72 hours after the order was obtained.	R 349	A hospital, "History 12/23/10, indicated assisted living due (times) 2 this morni (test for blood) from Department) Staff that the emesis apport here by far 23 hour observation. The hospital return indicated, "noas (physician's name) There was a lack oresident's record to coffee-ground emereturned from the histatus after returning the Residential Uning an interview the Residential Uning documentation in the resident's cond. 2. Resident #64's in 01/12/11 at 10:25 a included, but were Disease and osteo. A physician's order resident had an about the right foot. The Silvadene Cream (dressing daily for 1 physician of the here. A, "Skin Circumstain resident's right foot.	and Physical", dated, "sent here from the coffee-ground eming, also hemoccult-renthe ED (Emergency for the ED (Emergency for the ED (Emergency for the assisted living peared coffee-ground milyShe was admitted" orders, dated 12/24/spirinuntil okay with spirinuntil okay with spirinuntil okay with sis, went to the hospital, and the resident sis, went to the hospital, and the resident for the resident's record was reviewed a.m. The resident's record was reviewed a.m. The resident's dottlimited to, Atzheir arthritla, dated 12/15/10, indiscessed lesion on the order indicated to aptopical antibiotic) and 0 days and then notificated the was assessed each	ne esis x cositive / / noted if and was ed under flo, it had a itel, itent's on liagnoses mer's icated the etop of ply ia y the	R 349				

Indiana State Department of Health

No. 7444/ P. 102 PRINTED: 02/07/2011 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING B. WING		(X3) DATE 8 COMPLI	(X3) DATE SURVEY COMPLETED		
	155764			B. WING_		01/1	4/2011	
			DRESS, CITY,	STATE, ZIP CODE				
SPRING MILL HEALTH CAMPUS 101 W 87T. MERRILLV			· · ·					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION S	OVIDER'S PLAN OF CORRECTION (XS) CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY) (XS) COMPLIANCE DEFICIENCY		
R 349	Continued From pa	ge 20°		R 349				
l	There was a lack of documentation in the resident's record to indicate the right foot had been assessed after 12/17/10.							
	During an interview on 01/12/11 at 10:50 a.m., the Residential Unit Manager indicated the resident's right foot assessment had not been documented since 12/17/10. She indicated the healing status should have been assessed and documented.							
	3. Resident #46's record was reviewed on 01/11/11 at 1:45 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and Alzheimer's Disease.							
	The physician's recapitulation orders, dated 01/11, indicated an order received 09/29/10 for accurchecks (blood sugar monitoring) to be completed daily at 6 a.m. and 4 p.m The order indicated the resident was on the following Humulin regular insulin sliding scale (insulin given per result of the blood sugar result): < (less than) 151= no insulin 151-200= 2 units of insulin 201-250= 4 units 251-300= 6 units 301-350= 8 units 361-400= 10 units > (over) 400= call the physician				•			
	blood sugar at 4 p.r 01/07/11 was 315, a was a lack of docur	/11, indicated the rem. on 01/03/11 was 2 and 01/08/11 was 27 mentation to indicate sident received on the	235, 0. There how					
	During an interview on 01/11/11 at 1;50 p.m., the							

Indiana (State Department of	Health	· · · · · · · · · · · · · · · · · · ·					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEN/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING B, WING			(X3) DATE SURVEY COMPLETED		
NAME OF D	פאוומפון אס פוומפון ובם		STREET ADD	RESS CITY S	TATE, ZIP CODE	1 01/1/	77-4-11	
404 tM 971					INIM EX CODE	•		
SPRING	MILL HEALTH CAMP	US	MERRILLY	ille, in 4	5410			
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R 349	Continued From pa	ge 21	\neg	R 349				
	Residential Unit Ma	nager indicated the	amount of		•			
	insulin was not mar	ked on the MAR.						
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